Baton Rouge Rehab Hospital

Unit:_____Requester's Name:_____

Unit Fax #:_____Unit Phone #:_____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME OF INDIVIDUAL (PRINT)		DATE OF BIRTH		DATE
ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER

I hereby authorize Baton Rouge Rehab to use and/or disclose the information checked and/or listed below for the time period beginning on ____/____/____ and ending on ____/____/____.

Date Date

□ Billing Statements □ Care Plans □ Complete Health Care Record(s) □ Consultation Reports □ Dental Records □ Diagnoses (including those relating to alcohol, drug abuse, mental health, AIDS or HIV status, if any) □ Discharge Status □ ER Department Record □ Genetic Testing □ History and Physical Examination	□ Lab Reports (including alcohol or drug screening, if any) □ Marketing (explain):_____ _____ □ Nurses' Notes □ Operative Reports □ Pathology Reports □ Photographs, Video Tapes, Digital or other images □ Physician Orders □ Physician's Progress Notes/ Integrated Progress Notes □ Psychosocial Assessment	□ Psych Eval based on testing material □ Verbal Reports □ X-Ray Reports □ Other:_____ _____ □ Other:_____ _____ □ Other:_____ _____ □ Other:_____ _____

The information checked and/or listed above is to be released to: _____ for the following purpose(s):

□ Continuation of Treatment
□ Application of Insurance
□ At the Individual's Request
□ Processing of Insurance Claim
□ Attorney (Name) _____
□ Other (specify): _____

Release Records Electronically? ☐ Yes ☐ No

For Electronic Records Release: ☐ Release to patient through secure email. Email address:_____

- If authorizing certain marketing activities, I understand that the individual, organization, or entity receiving my health information may receive financial or in-kind compensation in exchange for using or disclosing the information described above.
- Unless otherwise revoked by me, I understand that this authorization will expire in one year or upon the completion of the use or disclosure of the information for the purpose it was intended, whichever is earlier.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I understand that I may inspect and copy and information used or disclosed under this authorization. I understand that a fee may be charge for such copying services.
- I hereby release the facility, its employees, officers, and healthcare professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that I may revoke this request at any time by providing the facility with my written notice of such revocation as outlined in the facility's Joint Notice of Privacy Practices.
- I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization.
- I understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

_____ Signature of Individual

_____ Signature of Witness

_____ Printed Name of Individual

_____ Printed Name of Witness

_____/_____/_____ Date

_____/_____/_____ Date

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A copy of this record must be provided to the person making the request and a copy must be filed in the Medical Record.
If representative is signing, the relationship to individual should be listed. If individual is under 18, the parent or guardian must sign.