# Authorization for Use and Disclosure of Protected Health Information (PHI)

| Patient Legal Name | Birthdate | Social Security No. *(optional)* |
|---|---|---|
| Address | | |
| City | State | Zip Code |

| INFORMATION TO BE RELEASED TO (Requestor) | Facility (Covered Entity Provider) authorized to release PHI |
|---|---|
| Name | Name Drs. Schwartzenburg, Lafranca, Guidry & Chapman |
| Address | Address 500 Rue de la Vie St., Suite 210 |
| City State Zip | City Baton Rouge State LA Zip 70817 |

**This authorization shall expire on the following date or event: _____ . If I fail to specify an expiration date or event, this authorization will expire (12) months from the date on which it was signed.**

***Purpose of disclosure:***

☐Medical Care ☐Legal ☐Insurance ☐Personal ☐Other _____

**DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED Starting _____ Ending _____**

| | Starting Date | Ending Date | | Starting Date | Ending Date |
|---|---|---|---|---|---|
| ☐ All PHI in the medical records | | | ☐ Consultation Reports | | |
| ☐ History and Physical Reports | | | ☐ Discharge Summary | | |
| ☐ Progress Notes | | | ☐ Itemized Billing Statement | | |
| ☐ X-Ray Tests/Reports | | | ☐ Patient Information Form | | |
| ☐ Laboratory Reports | | | ☐ Other Specified: | | |

**The Protected Health Information listed below WILL BE released when included in the above medical information unless specifically indicted otherwise.**

Psychiatric/Mental Information
Alcohol/Drug/Substance Abuse Information
AIDS/HIV/Genetic Information
OTHER _____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I understand that I have the right to revoke this authorization at any time in writing and must present the written revocation to the provider authorized to release the protected health information. I understand if I do revoke this authorization it will not apply to information that has already been released to this authorization.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

| *I have read the above and authorized the disclosure of the protected health information as stated:* | |
|---|---|
| (1) Patient Signature _____ Date: | |
| (1) PATIENT REPRESENTATIVE SIGNATURE (IF APPLICABLE) | (2) RELATIONSHIP TO PATIENT<br>Date: |