



RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Account #: _____

I. Authorization:

- For _____ to disclose my health care information to
Dr. _____ Fax: _____ at Louisiana Women's Healthcare.
- For Louisiana Women's Healthcare to disclose my health care information to:
Name: _____
Address: _____
Phone: _____ Fax: _____

II. You may use or disclose the following health care information:

- Entire Content of Record
- Entire Content of Record (excluding STDs, HIV, behavioral health, mental health, genetic/genomic information, or treatment for alcohol and drug abuse)
- Only the Following Content (specify) _____

III. Purpose:

- At my request
- Relocation
- For Insurance Change
- Other: _____
- Check here only when Louisiana Women's Healthcare Associates requests the authorization for marketing purposes
- Check here only when Louisiana Women's Healthcare Associates will get something of value for providing health information for marketing purposes

IV. This authorization ends:

- On (date) _____
- When the following event occurs _____

V. My Rights:

- I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.
- I may revoke this authorization in writing by sending a letter to the health care provider to whom the authorization is directed. If I did, it would not affect any actions already taken by the health care provider based upon this authorization.
- I may not be able to revoke this authorization if its purpose was to obtain insurance.
- I understand that once the health care provider discloses my health information, the person or entity that receives it, may re-disclose it. The HIPAA Privacy laws may no longer protect it.

****This request form can be mailed or faxed to Louisiana Women's Healthcare.**

Patient signature

Date

Individual legally authorized to sign on behalf of patient

Relationship to patient