AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)	DOB

ADDRESS	SSN

CITY	STATE	ZIP

PROVIDER AUTHORIZED TO RELEASE THE PHI	ENTITY RECEIVING THE PHI
_____ _____ _____ _____	EAST JEFFERSON AMBULATORY SURGERY CENTER 4320 HOUMA BOULEVARD #500 METAIRIE, LOUISIANA 70006 **ATTENTION: Wendy**

This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire 12 months from date signed.

Date: **Event:**

Purpose of this Disclosure:

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

	Description	Start Date	End Date
☐	All PHI in the record		
☐	Anesthesia Record		
☐	Laboratory Tests		
☐	X-Ray Reports		
☐	EKG Reports		
☐	Consultation Reports		
☐	History and Physical Examination		
☐	Progress Notes		
☐	Other		

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results

[ ] Psychiatric or mental care / treatment

[ ] Alcohol, drug or substance abuse treatment

[ ] Other (specify):

I UNDERSTAND THAT:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requestor 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 disclosed.
5. I have the right to receive a copy of this form after I sign it.

Signature of Patient:	**Date:**
Signature of Patient's Representative (if necessary):	**Date:**
Relationship to Patient:	