

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:		
The North Institute 29301 North Dixie Ranch Rd Lacombe, LA 70445 (985) 871-4114 Phone (985) 871-4130 Fax		NAME		
		ADDRESS		
		CITY	STATE	ZIP
		ATTENTION:		
This authorization will expire on the following date or event:				
Date:		Event:		
Purpose of this Disclosure:				
PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE				
Description		Start Date	End Date	
<input type="checkbox"/> All PHI in the record				
<input type="checkbox"/> Progress Notes				
<input type="checkbox"/> Laboratory Tests				
<input type="checkbox"/> X-Ray Tests / Reports				
<input type="checkbox"/> History and Physical Examination				
<input type="checkbox"/> Discharge Summary				
<input type="checkbox"/> Consultation Reports				
<input type="checkbox"/> Itemized Billing Statement				
<input type="checkbox"/> 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: <ol style="list-style-type: none"> 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 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 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:		
Personal Representative's Relationship to Patient:				