Authorization for Use of Protected Health Information (PHI)

Patient's Full Legal Name :	Date of Birth :	
Address :	Phone Number :	

I _____, hereby authorize
Patient's full legal name

☐ Slidell Memorial Hospital
☐ SMH Physician Network (Specify Clinic Physician)
Provider Name: _____
Address: _____

to release to _____
Specific name of hospital/physician/service agency or third party

_____
Adress City State Zip

_____
Telephone # Fax #

the following information from my medical record:

- ☐ All PHI in the record
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ Consult Report
- ☐ Radiology Images
- ☐ Laboratory Reports
- ☐ X-Ray Reports
- ☐ Progress notes
- ☐ Itemized billing statement

Specify Dates of Services:

From _____ To _____

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

Purpose for Release ___Medical ___Insurance ___Legal ___ Other _____

Method of Delivery ◯ Paper ◯ Fax # _____ ◯ Email _____

Redisclosure: I understand that, if the person or entity receiving the information is not a health-care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements (Fed. Reg. 42 C.F.R. Part 2).

Revocation/Expiration: I understand that I may revoke this authorization by notifying, in writing, the Health Information Management Department, knowing that previously disclosed information would not be subject to my revoke request. In any event, it will expire 365 days from this date, unless sooner revoked.

Refusal to sign: I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

Patient's right to inspect/obtain copy: The patient has a right to inspect and/or obtain a copy of the PHI to be used and/or disclosed. Fee for copies shall not exceed the amount defined by Louisiana law. Fee schedule is available in the Health Information Management Department.

Signature _____ Date _____
Patient (or legally authorized respresentative)

Print name of legal representative _____

Relationship to patient _____

Witness _____ Date _____

A copy of this authorization will serve as the original