



**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

*The Region's Most Comprehensive Care in the Neurosciences*

**Patient Name:** \_\_\_\_\_ **Medical Record Number:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

Is this address where you want the medical records sent?  Yes or  No (If **NO**, please list alternate address)

**Alternate Address:** \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

The NeuroMedical Center Surgical Hospital  
**Attention: Surgical Hospital Medical Records**  
10105 Park Rowe Circle • Baton Rouge, LA 70810  
Phone: 225.906.4812 • Fax: 225.768.2701

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate):

- Problem list
- Medication list
- List of allergies
- Immunization record
- Most recent History and Physical
- Most recent Discharge Summary
- Laboratory results from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
- X-ray and imaging report from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
- Consulting reports from (doctor's name) \_\_\_\_\_
- Entire record

**Other:** \_\_\_\_\_

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization: *(If you would like to give a family member or another individual/organization access to your medical records please list their name and address below.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For the purpose of: \_\_\_\_\_

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition \_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information that carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer at (225) 906-4809.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient if signed by Personal Representative

\_\_\_\_\_  
Signature of Witness

Please allow 10 business days for the completion of processing your request. Upon completion you will receive an invoice from the company IOD, who is our contracted release of information provider. The charges are as follows: \$1.00 per page for pages 1-25 \$0.50 per page for pages 26-500 \$0.25 per page for pages 501 +

*If your medical records are being directly sent to a physician there will be no charge.*