

**AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION (PHI)**

Patient Name: _____ Patient Account 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)

Alternative Address: _____

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

The Neuromedical Center Clinic
Attention: Clinic Medical Records Department
10101 Park Rowe Avenue • Suite 200
Baton Rouge, LA 70810
Phone: 225.768.2087 • Fax: 225.768.2196

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

_____ Progress Notes	_____ Consultations Reports	_____ Laboratory Tests
_____ X-Ray Test / Reports	_____ History and Physical Examination	
_____ Discharge Summary	from (date) _____ to (date) _____	
_____ Itemized Billing Statement	from (date) _____ to (date) _____	
_____ All PHI in medical record	from (doctor's name) _____	

Other: _____

3. 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.

4. 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(s) and address below).**

For the purpose of: _____

5. I understand that I have a right to revoke this authorization at anytime. 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 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 12 months from date signed.

6. 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 any questions about the disclosure of my health information, I can contact the Privacy Officer at (225) 768-2065.

Signature of Patient or Personal Representative

Date

Relationship to Patient if signed by Patient Representative

Signature of Witness

Please allow 3 to 7 business days for the completion of processing your request. Upon completion you will receive an invoice from the company IOD. This 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.

Received by _____ **Date** _____