THE NEUROMEDICAL CENTER REHABILITATION HOSPITAL

10101 Park Rowe Avenue, Suite 600, Baton Rouge, Louisiana 70810

Authorization to Disclose Health Information

Patient Name: _____ Medical Record #: _____ DOB: _____

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: (please list address)

_____

_____

_____

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

- o Problem list
- o Medication list
- o List of allergies
- o Immunization record
- o Most recent History & Physical
- o Most recent Discharge Summary
- o Laboratory Results from (date) _____ to (date) _____
- o X-ray and imaging reports from (date) _____ to (date) _____
- o Consulting Reports from (doctor's name) _____
- o Entire Record
- o 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: (please list address)

_____

_____

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 NeuroMedical Center Rehabilitation Hospital, 10101 Park Rowe Avenue, Suite 600, Baton Rouge, LA 70810, Attn: Privacy Officer. 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 @ (225)906-2999.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

If signed by Personal Representative – Relationship to Patient Signature of Witness