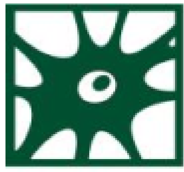

10101 Park Rowe Ave. Suite 200
Baton Rouge, LA 70810
Phone: 225.769.2200 FAX: 225.768.2196

Request for Access To and Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Name:______________________________ Date of Birth:______________________

Street Address:______________________________ Tel # (cell):______________________

City, State ZIP:______________________________ Tel # (home):______________________

Email Address:______________________________ Tel # (work):______________________

I request my records to be delivered by: ___ Electronic Delivery ___ Mail (paper) ___ Picked Up (paper) ___ Fax to Healthcare Provider
**Films cannot be provided electronically and are available on a disc for mailing or Patient pick-up only*

I hereby authorize______________________________ **to Disclose my Protected Health Information to:**

Facility/Individual Name:______________________________ Relationship:______________________

Attention:______________________________ Fax #: ______________________

Street Address:______________________________ Tel #: ______________________

City, State ZIP:______________________________ Email Address:______________________

Information Be Released for TREATMENT DATES: From (date): ______________ **To (date):** ______________

TYPE OF INFORMATION TO BE RELEASED:
__ Office Notes Only
__ Complete Health Record
__ Itemized Billing Statement
__ Radiology Reports Only
__ X-ray Images (disc only)
__ Other:______________

PURPOSE OF THE REQUEST for PHI DISCLOSURE:
__ Treatment/Consultation
__ Personal Request
__ Insurance
__ Legal

Drug and / or Alcohol Abuse, and / or Psychiatric, and / or HIV / AIDS Records Release:
I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check one:*** __ **Yes** __ **No**

Time Limit & Right to Revoke Authorization:
Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Department of Health Information Systems or other Department to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event______________, or 90 days from the date of signature, unless otherwise specified.

Re-release:
I understand that the information released pursuant to this Authorization may be subject to release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Cost of Records:
The cost of copies of **medical records for your personal use is $6.50 (electronic)** ***per request*****, and MRI/Xray Images are $10 per disc with payment due in advance and made payable to ResolveROI**. Requests for continuing care and records provided directly to another healthcare provider will be at no cost, unless transferring to another healthcare provider, and all other requests will be billed at applicable rates. Please **contact ResolveROI via email at Support@ResolveROI.com or call 844-887-8109 for questions** regarding your record request.

Signature of Patient or Personal Representative Who May Request Disclosure
By signing below, you authorize your healthcare provider identified above to release your protected health information, and acknowledge and understand the terms of this **Request for Access to and Authorization for Use and Disclosure of Protected Health Information**.

Patient / Personal Representative signature: ______________________________ Date: ______________

Relationship to Patient: ____