

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

Patient's PRINTED Name:	Birthdate:	Social Security No
Address:		Phone Number: (    )

I hereby authorize \_\_\_\_\_ to disclose records obtained in the course of my evaluation and/or treatment to: (Name and address of person(s) or organization(s) to which disclosure is to be made)

(1) Name: <b>Thibodaux Orthopaedic &amp; Sports Medicine Clinic</b> Phone Number : ( 985 )446-6284	Address: <b>525 St. Mary Street; Thibodaux, LA 70301</b> Fax Number: ( 985 ) 447-1754
(2) Name: Phone Number : (    )	Address: Fax Number: (    )

**Medical Records:** (Entire Record or Selected Portions of PHI as marked)

Description:	Description:	Description:
<input type="checkbox"/> <b>Entire Records</b> ( or Portions): <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Room Records <input type="checkbox"/> History and Physical <input type="checkbox"/> Consult Report(s) <input type="checkbox"/> Operative Report(s) <input type="checkbox"/> Rehab Services Type: _____  <b>Date(s)</b> _____	<input type="checkbox"/> Lab <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Record <input type="checkbox"/> Psychological Record <input type="checkbox"/> Psychiatric Record(s) <input type="checkbox"/> Doctor Progress Notes <input type="checkbox"/> Physician Orders <input type="checkbox"/> Pathology Report  <b>Date(s)</b> _____	<input type="checkbox"/> Other _____  <input type="checkbox"/> <b>Billing Records *</b>  <b>Date(s)</b> _____

\_\_\_\_\_(Initials) I DO  or I DO NOT  consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV(AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information: \_\_\_\_\_

List the purpose(s) for the release or disclosure of Protected Health Information:  
  
\_\_\_\_\_

***This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken and if not earlier revoked. To revoke this authorization contact HELEN DUFRENE at 985-446-6284.***

This consent will expire on the following date or event:  
  
Expiration date: \_\_\_\_\_ or Expiration Event: \_\_\_\_\_

- I understand that:**
1. I may refuse to sign this authorization and it is strictly voluntary.
  2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
  3. Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization
  4. I have the right to receive a copy of this authorization.

***I have read the above or have had it read to me and I authorize the disclosure of the Protected Health Information as stated.***

SIGNED: _____ (Signature of Patient/Legal Guardian or Representative*) If signed by other than patient, indicate relationship: _____	DATE: _____
Witness: _____	DATE: _____

*\*Authorized representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.*

**To the Party Receiving this Information:** This information has been disclosed to you from the records whose confidentiality may be protected by state and/or federal law. Certain regulations prohibit you from further disclosure of it without the specific written consent of the person to whom it pertains, or otherwise as permitted by such law and regulations. A general authorization for the release of such medical or other information is not sufficient for this purpose. Fees will be charged for the release of information in accordance with the law.