AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

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

I hereby authorize THIBODAUX ORTHOPAEDIC AND SPORTS MEDICINE CLINIC 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: **Address:**
Phone Number : ( ) **Fax Number: ( )**

(2) Name: **Address:**
Phone Number : ( ) **Fax Number: ( )**

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

Description:	**Description:**	**Description:**
[ ] Entire Records	[ ] Lab	[ ] Other_____
(or Portions):	[ ] Imaging/Radiology	_____
[ ] Discharge Summary	[ ] Nursing Notes	[ ] **Billing Records ***
[ ] Emergency Room Records	[ ] Medication Record	
[ ] History and Physical	[ ] Psychological Record	
[ ] Consult Report(s)	[ ] Psychiatric Record(s)	
[ ] Operative Report(s)	[ ] Doctor Progress Notes	
[ ] Rehab Services	[ ] Physician Orders	
Type:_____	[ ] Pathology Report	
Date(s)_____	**Date(s)_____**	**Date(s)_____**

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

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.