AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)	DOB

ADDRESS	SSN

CITY	STATE	ZIP

ENTITY RECEIVING THE PHI:	PROVIDER AUTHORIZED TO RELEASE THE PHI:
Premier Pediatrics of Acadiana 1512 Chemin Metairie Rd, Suite B Youngsville, LA 70592 Fax: 1-866-301-1073	NAME ADDRESS CITY / STATE / ZIP ATTENTION:

This authorization will expire on the following date or event:

Date: **Event:**

Purpose of this Disclosure: ❑ Transferring records to another physician REASON: _____
❑ Daycare/School ❑ Records to a Specialist ❑ Insurance Purpose ❑ Other: _____

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
❑ All PHI in the record		
❑ Progress Notes		
❑ Laboratory Tests		
❑ X-Ray Tests / Reports		
❑ History and Physical Examination		
❑ Discharge Summary		
❑ Consultation Reports		
❑ Itemized Billing Statement		
❑ Other:		

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results [ ] Psychiatric or mental care / treatment
[ ] Alcohol, drug or substance abuse treatment [ ] Other (specify):

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. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE DISCLOSED.
5. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

Signature of Patient:	**Date:**
Signature of Patient's Representative (if necessary):	**Date:**
Personal Representative's Relationship to Patient:	