BATON ROUGE
CARDIOLOGY CENTER

Authorization to Release Protected Health Information (PHI)

Please complete this form in its entirety so we can help you receive the information you are requesting. All fields are required. Incomplete/incorrect forms cannot be processed.

Patient Name:		
Address:		
City:	State:	Zip:
Home Phone:	Work #:	Cell #:
Date of Birth:	Social Security Number:	
Account:	Physician:	

I hereby authorize Baton Rouge Cardiology Center, to release my protected health information to:

Individual/Person:	Company/Organization:	
Address:		
City:	State:	Zip:
Phone:		

Please release the following information:

- ❑ All information including the diagnosis and records of any treatment or examination rendered to me during the period from ____________________________________ to _____________________________________.
- ❑ The following test(s)/information only: ____
  ____

- ❑ All PHI in the medical records
- ❑ X-Ray Test/Reports
- ❑ Consultation Reports
- ❑ Itemized Billing Statement
- ❑ Laboratory Reports
- ❑ Other (specify information to be released in the space)____
- ❑ Patients Information Form
- ❑ History and Physical Reports
- ❑ Progress Notes
- ❑ Discharge Summary

The purpose of this disclosure:

- ❑ Continuation of Care/Transfer of Care
- ❑ Workman's Compensation
- ❑ Attorney/Legal
- ❑ Insurance Company
- ❑ Relocation
- ❑ Other (specify):______________

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I understand the information be released, which may include: alcohol and drug abuse/treatment; physical and social work counseling; HIV, AIDS, or ARC; communicable disease or infection, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis; genetic information and demographic information, for the purposes and conditions designated on this form.

I understand that Baton Rouge Cardiology Center is not responsible for any subsequent disclosure of protected health information as a result of providing this information to the above-mentioned parties. I further understand that I am not required to disclose to Baton Rouge Cardiology Center the reason for this request and that I may subsequently revoke this request if necessary.

I understand that I may refuse to sign this authorization and that it is strictly voluntary. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.

I understand that I have the right to revoke this authorization at any time in writing and must present the written revocation to the provider authorized to release the protected health information. I understand if I do revoke this authorization it will not apply to information that has already been released to this authorization. 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 re-disclosed.

Signature of patient or legally authorized representative:	Date:
Printed name of person signing *(If not patient):*	Relationship to patient:

This authorization expires one year from the original date.

Note: If patient is deceased, a copy of the patient's death certificate must be submitted to medical records so it can be added to the patient's chart.

For Clinic Use Only

❑ Records sent from clinic – please image form to patient record

❑ Mailed ❑ Picked up ❑ Faxed

Date Received_______________Date Processed______________Processed By________________

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