

Authorization to Release Health Information

I, _____, hereby authorize **Greater New Orleans Surgery Center** (the "Facility") to disclose health information regarding the following patient:

Patient Name: _____
 Address: _____

Date of Birth: _____
 Patient's Phone: _____

1. The information is to be disclosed to the following persons or organizations:
 Name: _____
 Address: _____

2. Purpose. The purpose of the use or disclosure is:
 At the request of the patient
 Other: _____

If the purpose is for marketing, will the Facility receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? YES NO

3. Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around _____ (insert dates):

The following medical records:

<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Progress notes
<input type="checkbox"/> Lab results	<input type="checkbox"/> Photographs, videotapes, or other images
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Mental or behavioral health records
<input type="checkbox"/> Consultation reports	<input type="checkbox"/> Psychotherapy notes
<input type="checkbox"/> X-ray reports	<input type="checkbox"/> Genetic test results
<input type="checkbox"/> HIV/AIDS test results and treatment	<input type="checkbox"/> Entire medical record
<input type="checkbox"/> Alcohol and drug treatment records	<input type="checkbox"/> Summary of treatment
<input type="checkbox"/> Other (specify): _____ _____	

The following billing and payment information:

Other information:

4. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Facility. However, the revocation will not have any effect on any uses or disclosures the Facility may have made before the revocation was received.

5. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed.
6. Redisclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.
7. Refusal to Sign. I understand that I may refuse to sign this Authorization and that the Facility will not condition treatment on whether I sign this Authorization.
8. Certification. I certify that I am (*check whichever applies*):
 - the patient, and the identification that I have provided is true and correct.
 - the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: _____.

Signed this _____ day of _____, 200__.

Signature: _____
 Print name: _____
 Address: _____
 Phone No: _____

Witness: _____
 Print Name: _____
 Date: _____

(ONE COPY TO BE RETAINED BY THE PATIENT)

For Office Use Only:	
Date received: _____	Expiration date: _____
How was identity verified? _____	Copy made? <input type="checkbox"/> Yes <input type="checkbox"/> No
How was authority verified?: _____	Copy made? <input type="checkbox"/> Yes <input type="checkbox"/> No
By: _____	Title: _____ Date: _____