AUTHORIZATION FOR RELEASE
PROTECTED HEALTH INFORMATION
(PHI)

Acadiana Women's Health Group, APMC
4640 Ambassador Caffery Parkway
Lafayette, La 70508
337.984.1050 / 337.984.8776 (fax)

Patient:

Name_____ Date of Birth_____ Phone #_____

Address_____ Social Security # _____ - _____ - _____

City_____ State_____ Zip Code_____

Information Released From:

Physician/Clinic Name_____ Phone #_____

Address_____
(City) (State) (Zip Code)

Information Released To (recipient):

Name_____ Phone #_____

Address_____
(City) (State) (Zip Code)

Medical record information to be released: start date_____ end date_____

____Office visit/telephone notes
____Mammogram results
____Pap results
____Lab/test results
____Hospital reports
____Operative procedure reports
____Abstract/pertinent information
____Prenatal records
____Ultrasound
____DEXA (Bone Density)
____Other_____

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

- Treatment for alcohol and/or drug abuse (substance abuse)
- Psychiatric or mental care/treatment
- HIV related information (AIDS related testing)
- Sexually transmitted disease related information and testing
- Genetic testing

Reason for release:

____Consult/second opinion, personal
____Legal
____Insurance underwriting
____Out of town – move
____Selected new physician
____Referred by doctor/continuing care
____School
____Other_____

- I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I understand when my information is used or disclosed pursuant to this authorization it may be subject to redisclosure by the recipient and may no longer be protected by Federal HIPAA privacy rule.
- I understand that I may revoke the authorization at any time (provided such revocation is in writing to the providing organization's privacy official) except to the extent that the practice has acted in reliance upon this authorization.
- The consent will automatically expire on the following date, event_____ or if not indicated in one year.
- I have a right to receive a copy of this form after I sign it.

I authorize the above provider to release the information marked above to the recipient.

Signature of Patient_____ Date_____

Signature of Legal Guardian_____ Date_____

Legal Guardian Name (print)_____