Woman's

Authorization to Release Health Information to Woman's Hospital

_____(Patient's Name) D.O.B _____

hereby authorize appropriate personnel at_____to release my health information to, and/or allow my records to be reviewed by:

Recipient(s):	***Woman's Hospital***
Recipient's Address:	***100 Woman's Way Baton Rouge, LA 70817***
Attention:	

Purpose of Release

- ❑ for Treatment at Another Facility
- ❑ for Treatment by a Physician
- ❑ for Application for Insurance
- ❑ for Research
- ❑ for Processing of my Insurance Claim
- ❑ Personal (at my request)
- ❑ for an Interview
- ❑ for referral to care coordination for substance use disorder (Woman's Hospital GRACE Program or other)
- ❑ for Publication, Broadcast, or Other Dissemination by the hospital or news media
- ❑ Other Reasons; Specify:_____

Specify information to be released by placing a check mark in the appropriate box(es):

Dates of Services	

- ❑ Clinic Record
- ❑ Consultation Reports; Specify Doctor
- ❑ Demographic Information
- ❑ Diagnosis
- ❑ Discharge Summary
- ❑ Emergency Room Record
- ❑ Entire Record
- ❑ Entire Billing Record
- ❑ History & Physical
- ❑ Imaging Results
- ❑ Immunization Record
- ❑ Itemized Bill
- ❑ Lab Test Results
- ❑ Nurses Notes
- ❑ Operative Report
- ❑ Photograph/Video
- ❑ Physician Orders
- ❑ Physician Progress Notes

- ❑ Other Records; Specify: _____
- ❑ Information Concerning Illness, surgery, or events surrounding the birth of my child

Special consent is required to release the following information. Indicate Your Authorization by placing a checkmark in the appropriate box(es). NO INFORMATION WILL BE RELEASED IF BOX IS NOT CHECKED.

The following substance use disorder information: ❑ History & Physical ❑ Medications ❑ Demographics ❑ Diagnosis ❑ Discharge Summary and or Instructions ❑ Lab Results ❑ Orders (Physician/LIP) ❑ Progress Notes (Physician/LIP) ❑ Psychiatric Evaluation ❑ Treatment Plan

- ❑ Other; Please specify_____
- ❑ All Substance Use Disorder treatment records – *(Includes all alcohol, drug or other substance use disorder records maintained by the provider/treatment program, relating to the patient, including all admission forms and demographic information, medication, medical history, orders (physician/LRP), psychiatric evaluation, clinical testing information and other treatment information.)*

- ❑ HIV or AIDS test results
- ❑ Genetic test results; Specify (required)
- ❑ Behavioral or Mental Health records/test results/diagnosis

Marketing

If I am providing authorization for marketing purposes, I understand that:

- ❑ Woman's Hospital will not receive a monetary benefit from a third party for the use of my patient information.
- ❑ Woman's Hospital will receive a monetary benefit (directly or indirectly) from a third party for use of my patient information.

Authorization Expiration Date or Event

Unless otherwise revoked, this authorization will expire on the indicated date, event or condition. If an expiration date, event or condition is not specified below, this authorization will expire in one (1) year. For genetic information, the expiration date shall in no event be more than 60 days. The statement "end of research," "none," or similar language is sufficient if disclosure is for research, (except for research on genetic information) including the creation and maintenance of a research database or repository.

Expiration (Month,Day,Year / Event / Condition) _____

REQUIRED STATEMENTS

I understand that:

1. Authorizing the release of this health information is voluntary and I can refuse to sign this authorization.
2. I have the right to revoke this authorization at any time *(upon written notification to the Health Information Management Department at Woman's Hospital)* except to the extent that Woman's Hospital has already released the health information before receipt of the revocation. For genetic information, I have the right to revoke the authorization at any time before the disclosure is actually made or when I am made aware of the details of the genetic information.
3. If the authorization is for research, the researcher may continue to use and disclose the health information collected prior to the receipt of the written revocation.
4. Woman's Hospital cannot condition treatment, payment, enrollment, or eligibility for benefits on the patient providing this authorization.
5. If the authorization is for research-related treatment, Woman's Hospital may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research.
6. Any release of information carries with it the potential for an unauthorized redisclosure by the Recipient and the information may not be protected by federal law.
7. The authorization shall be invalid if used for any other purpose other than the described purpose for which the disclosure is made.
8. A photocopy of this authorization may serve as an original.

Patient's Signature _____ Date _____

Personal Representative's Signature (if necessary) _____ Date _____

Personal Representative

If it is necessary for a personal representative to sign and date this authorization due to lack of capacity of the patient, including minority, interdiction or any other legal reason, indicate below how the person signing as representative has authority to do so:

- ❑ The ***court appointed person acting for the patient,*** if one has been appointed.
- ❑ An agent acting pursuant to a valid mandate, specifically authorizing the agent to make health care decisions.
- ❑ The patient's spouse not judicially separated.
- ❑ An adult child of the patient.
- ❑ Any parent, whether adult or minor, for his minor child.
- ❑ The patient's sibling.
- ❑ The patient's other ascendants or descendants.
- ❑ Any person temporarily standing in ***for the parents,*** whether formally serving or not, for a minor under his care and any guardian for his ward.
- ❑ Other (Please specify): _____

For Office Use Only:

Date copy of authorization given to patient _____

Date copy of authorization mailed to patient _____

Date records sent _____