LSU Health
Healthcare Network

RECORDS REQUESTED FROM OUTSIDE ENTITY/FACILITY TO LSU HEALTHCARE NETWORK

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:	Date of Birth:
Address:	Social Security Number:
City:	State/Zip Code:
Delivery Method:	Entity/Provider/Person Receiving PHI
☐Email secure format ☐USPS Mail ☐Fax (Healthcare Provider only)	Name: LSU HEALTHCARE NETWORK Phone: ___ Fax: ___ Attention:___

Purpose of Disclosure

☐**Establishing or Continuing care/Treatment**
Dates: From ______________________________To______________________________

PHI and Dates of PHI Authorized for Use and Disclosure

Description	Start Date	End Date
Complete Health record		
Progress notes		
Laboratory tests		
History & Physical Examination		
Consultation reports		
Radiology films		
Itemized billing statement		
Other:		

State and Federal laws protect the following information.
If this information applies to you, please indicate if you would like the information released/obtained (indicate dates to be released where appropriate:

Alcohol, Drug, or Substance Abuse records	Dates:	Yes		No	
HIV Testing and Results	Dates:	Yes		No	
Mental Health	Dates:	Yes		No	
Psychiatry and Psychotherapy records	Dates:	Yes		No	

Signature of patient/personal/legal representative who may request disclosure:

1. Any disclosure of information carries the potential for unauthorized **RE-DISCLOSURE**. Re-disclosed information may not be protected by federal confidentiality rules
2. I have the right to revoke this authorization at any time. Revocation does not apply to **INFORMATION PREVIOUSLY/RELEASED**
3. Treatment, payment, enrollment or eligibility is not a condition on whether I sign this authorization.

DATE	SIGNATURE OF PATIENT/PARENT/CONSERVATOR/GUARDIAN	AUTHORITY/RELATIONSHIP TO PATIENT