Authorization for Release of Protected Health Information

Patient Information:
Printed Name: ______________________________
Date of Birth: ______________________ SSN: ______________________
Address: ______________________________

Authority to Release Protected Health Information
I hereby authorize ______________________________(covered entity) to release the information identified in this authorization from the medical records of the patient listed above to: **SEALE, SMITH, ZUBER & BARNETTE, 8550 United Plaza Blvd., Suite 200, Baton Rouge, LA 70809.**

Information to be Released
You may disclose any of the following Protected Health Information for treatment dates 1998 to present.

Abstract/Pertinent	History & Physical	Discharge Summary(ies)	Consult
Operative Reports	Progress Notes	Physician Orders	Nurses Notes
ER Reports	Lab Results	Radiology Reports	Entire Chart
Itemized Bill	Radiological Films		

Purpose of the Requested Disclosure of Protected Health Information
I am authorizing the release of my Protected Health Information for the purpose of pursuing a legal claim.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

_________ (initial) I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release.

_____ (initial) I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to the above listed health care provider. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. I understand that my health care provider cannot condition future medical treatment, payment, enrollment or eligibility for benefits on the execution of this authorization.

The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

A copy of this authorization shall be sufficient and as good as the original. This release does not authorize verbal communications not otherwise permitted by law. This authorization will expire three (3) years from the date of signing or on ____.

I have read the above and authorize the disclosure of the Protected Health Information as stated.

____
Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient:

____
Signature of Witness Date