CHRISTUS ST. FRANCES CABRINI Health System

Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name:

_____ _____ ___ Date of Birth: _____ _____

Address: _____ Telephone: _____

Information to be Released – Covering the Periods of Healthcare

From (date) _____ _____ To (date) _____

Please check type of information to be released:

Complete health record	Diagnosis & treatment codes	Discharge summary
History and physical exam	Consultation reports	Progress notes
Laboratory test results	Radiology reports/images	Cardiac imaging
Photographs, videotapes	Complete billing record	Itemized bill
Discharge Instructions	Pulmonary function results	Immunization Record

Release Of Information (ROI) Abstract – History &Physical (H&P), Discharge Summary, Labor & Delivery Note, Operative Report, Procedure Note, Consultation, Laboratory, Pathology, X-ray reports.

Other (specify)_____

Purpose of Request

Treatment or consultation At the request of the patient Billing or claims payment Other _____

Send / Release Information

Paper CD Electronic Portal (E-mail notification when access is available)

E-mail Address: _____ _____ Unencrypted electronic transmissions are not secure. Although it is unlikely, there is a possibility that information in an encrypted electronic transmission can be intercepted and read by other parties besides the person to whom it is addressed. *Please initial if you have requested your information to be sent to you in an unencrypted electronic format. _____

Release to Name: _____ Mail to Name: _____ ____

Mail to Address: _____ _____ _____ _____

Substance Use Disorder, and/or Psychotherapy, and/or HIV/AIDS Records Release

I understand that if my medical or billing records contain information in reference to substance use disorder and/or psychotherapy treatment I have been afforded the opportunity to sign a specific authorization. Initial One: Yes_____ No _____ Not Applicable_____

I understand if my medical or billing records contain information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I have been afforded the opportunity to sign a specific authorization.
Initial One: Yes_____ No_____ Not Applicable _____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at CHRISTUS St. Frances Cabrini, 3330 Masonic Dr, Alexandria, LA 71301, or Janelle.thoms@christushealth.org. Unless revoked, this authorization will expire on the following date or event _____ or 180 days from the date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Reresentative or Legally Authorized Representative Who May Request Disclosure

I understand that I do not have to sign this authorization and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize CHRISTUS St. Frances Cabrini to release the protected health information specified above.
Signature:_____ Date: _____

Authority to Sign if not Patient: _____

Identity of Requestor Verified via: Photo ID Matching Signature Other, specify:____ _____ _____
Verified by: _____