AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize _____ to use or disclose the following protected health information from the
(Facility Name)
medical records of the patient listed below to:

Patient Name: _____
Patient DOB: _____
Patient Social Security Number: _____
Patient Address: _____
_____

Where do you want the information sent?

Recipient Name: _____

Recipient Address: _____

What records do you want? (Check appropriate boxes below)

Disclose the following PHI for treatment dates _____to_____

☐ Abstract/Pertinent	☐ History & Physical	☐ Discharge Summary	☐ Consult
☐ Operative Report	☐ Progress Notes	☐ Physician Orders	☐ Nurse Notes
☐ Lab	☐ X-Ray	☐ Entire Chart	

☐ Patient Portal Setup/Reset: _____
☐ CD/Secure electronic format: _____
☐ Other Specified: _____

The above information is disclosed for the following purposes:
☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other _____

_____ I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV or genetic information.
Initials

This authorization shall expire upon this expiration date: _____
** If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

- 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 Specialists Hospital Shreveport. I understand that the revocation will not apply to information that has already been released to this authorization.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

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

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