MARY BIRD PERKINS CANCER CENTER
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)		DOB
ADDRESS		SSN
CITY	STATE	ZIP

PROVIDER AUTHORIZED TO RELEASE THE PHI:	ENTITY RECEIVING THE PHI:
	Mary Bird Perkins Cancer Center Louisiana Hematology/Oncology Associates 4950 Essen Lane Baton Rouge, LA 70809

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 **6 (six)** months from date of signature. ***For genetic information, the expiration date must be sixty (60) days or less from date of signature***.

Expiration
(mm/dd/year; event or condition):_____

Expiration for Genetic PHI
(mm/dd/year):_____

Purpose of this Disclosure:
☐ Insurance ☐ Personal ☐ Legal ☐ Continuity of Care ☐ Other:_____

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
☐ All PHI in the Record		
☐ Demographic Information		
☐ Physician's Orders		
☐ Follow Up Visits		
☐ Consultation Reports		
☐ Treatment Summary Reports		
☐ Operative Reports		
☐ Pathology Reports		
☐ Imaging Reports		
☐ Laboratory Reports		
☐ Entire Billing Record		

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☐ Itemized Bill		

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

☐ Alcohol, Drug or Substance Abuse Records ☐ Genetic Records
☐ HIV Testing and Results
☐ Mental Health Records *(if applicable)*

***GENETIC TEST RESULTS – You must specify the test results to be released by checking or writing below**:*
Chromosome Analysis (specify below):
☐Blood ☐Bone Marrow ☐CVS ☐Prothrombin DNA ☐Her2/neu FISH for breast cancer

☐Amniotic Fluid ☐Tissue ☐Tissue ☐Urovysion ☐Cystic Fibrosis

☐Factor V Leiden ☐ Methylenetetrahydrofolate Reductace

☐Other_____

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

☐ MBPCC will not receive a monetary benefit from a third party for the use of my patient information.
☐ MBPCC will receive a monetary benefit (directly or indirectly) from a third party for the use of my patient information.

By signing this authorization form, I understand that:

1. Authorizing the release of this health information is voluntary and I can refuse to sign this authorization.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I have the right to revoke this authorization at any time (*upon written notification to the Health Information Management Department at Mary Bird Perkins Cancer Center*) except to the extent that Mary Bird Perkins Cancer Center 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.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have the right to receive a copy of this form after I sign it.
6. The authorization shall be invalid if used for any other purpose other than the described purpose for which the disclosure is made.
7. A photocopy of the authorization may serve as an original.

Signature of Patient:	Date:
Signature of Patient's Representative (if necessary):	Date:
Personal Representative's Relationship to Patient:	

For Office Use Only:
Medical Record Number: _____

Media of Records Disclosed (other than paper):
☐ CD
☐ Other _____