Mary Bird Perkins Cancer Center
Louisiana Hematology/Oncology Associates
NorthShore 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:**

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<tr>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
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<td>☐ All PHI in the Record</td>
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<td>☐ Demographic Information</td>
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MARY BIRD PERKINS CANCER CENTER
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

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
- [ ] HIV Testing and Results
- [ ] Mental Health Records *(if applicable)*
- [ ] 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
- [ ] Methylene tetrahydrofolate 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:**

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**For Office Use Only:**

**Medical Record Number:** ______________

**Media of Records Disclosed (other than paper):**

- [ ] CD
- [ ] Other ____________________________