OUR LADY OF THE LAKE PHYSICIAN'S GROUP
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 Northshore Oncology Associates MD Clinics 4950 Essen Lane Baton Rouge, LA 70809	NAME		
	ADDRESS		
	CITY	STATE	ZIP
	Contact Number: Fax Number:		

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		
☐	Itemized Bill		

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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 _____