

**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 Northshore Oncology Associates MD Clinics Lakeshore Surgical 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. <u>For genetic information, the expiration date must be sixty (60) days or less from date of signature.</u>				
Expiration (mm/dd/year; event or condition): _____				
Expiration for Genetic PHI (mm/dd/year): _____				
Purpose of this Disclosure: <input type="checkbox"/> Insurance <input type="checkbox"/> Personal <input type="checkbox"/> Legal <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Other: _____				
PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE:				
Description	Start Date	End Date		
<input type="checkbox"/> All PHI in the Record				
<input type="checkbox"/> Demographic Information				
<input type="checkbox"/> Physician's Orders				
<input type="checkbox"/> Follow Up Visits				
<input type="checkbox"/> Consultation Reports				
<input type="checkbox"/> Treatment Summary Reports				
<input type="checkbox"/> Operative Reports				
<input type="checkbox"/> Pathology Reports				
<input type="checkbox"/> Imaging Reports				
<input type="checkbox"/> Laboratory Reports				
<input type="checkbox"/> Entire Billing Record				

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<input type="checkbox"/> 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

- | | |
|---|--|
| <input type="checkbox"/> Alcohol, Drug or Substance Abuse Records | <input type="checkbox"/> Genetic Records |
| <input type="checkbox"/> HIV Testing and Results | |
| <input type="checkbox"/> 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):

- | | | | | |
|---|--------------------------------------|---------------------------------|--|--|
| <input type="checkbox"/> Blood | <input type="checkbox"/> Bone Marrow | <input type="checkbox"/> CVS | <input type="checkbox"/> Prothrombin DNA | <input type="checkbox"/> Her2/neu FISH for breast cancer |
| <input type="checkbox"/> Amniotic Fluid | <input type="checkbox"/> Tissue | <input type="checkbox"/> Tissue | <input type="checkbox"/> Urovysion | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Factor V Leiden <input type="checkbox"/> Methylenetetrahydrofolate Reductase | | | | |
| <input type="checkbox"/> 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:	

<p>For Office Use Only:</p> <p>Medical Record Number: _____</p> <p>Media of Records Disclosed (other than paper):</p> <p><input type="checkbox"/> CD</p> <p><input type="checkbox"/> Other _____</p>
