CENTER FOR RESTORATIVE BREAST SURGERY

Patient Authorization for Use/Release of Information

All Fields Must Be Completed For Processing

Patient Name: _____ Date of Birth: _____

Address: _____ Last 4 Digits of SSN: _____

City: _____ State: _____ Zip: _____

PROVIDER AUTHORIZED TO RELEASE THE PHI	ENTITY RECEIVING THE PHI
I hereby authorize Center for Restorative Breast Surgery or _____ ☐ to release ☐ to request medical information (protected health information) to/from the entity listed	Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

MEDICAL RECORD TO BE RELEASED

Dates of Treatment to be Released: _____ to _____

Or Specify a Date: _____

Check off items being released:

☐ Operative Report ☐ Pathology Report ☐ Labs

☐ History and Physical ☐ Radiology Reports ☐ Physician Office Notes

☐ Entire Record (Applicable Fees will be applied) ☐ Other _____

The patient's authorization is required to release certain types of records, including HIV test results, alcohol and/or drug abuse treatment and information, psychiatric treatment, and genetic testing (defined in the Genetic Information Non-Discrimination Act of 2008 – GINA, Section 2017 A and B. By placing an "X" in the following box(es), I am indicating that I DO NOT authorize the release of HIV test results, alcohol and / or drug abuse treatment, and genetic testing.

I DO NOT authorize the release of: ☐ HIV test results ☐ Alcohol/Drug abuse treatment/information ☐ Psychiatric treatment ☐ Genetic testing

PURPOSE OF RELEASE

☐ Personal ☐ Continuing Treatment ☐ Insurance ☐ Legal

☐ Other _____

REQUIRED STATEMENTS (Patient's / Requestor's Understanding)

- I understand that I have a right to revoke this authorization at any time. I understand that If I revoke this authorization, I must do so in writing and present written revocation to Center for Restorative Breast Surgery, Health Information Management Department; 1717 St. Charles Avenue, New Orleans, LA 70130. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company for services already rendered.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- Fee / charges will comply with all laws and regulations applicable to release of information.
- I understand authorizing the use of disclosure of the information identified above is voluntary. I do not need to sign this form to ensure healthcare treatment.

EXPIRATION

This authorization shall expire upon the expiration Date or Event: _____

If I fail to specify an expiration date, this authorization will expire 1 year from the date on which it was signed.

I have read the above and authorize the disclosure of the protected health information as stated.

_____	_____	_____
Signature of Patient/Legal Representative	Relationship to Patient	Date
_____	_____	_____
Signature of Witness (If patient is unable to sign)	Relationship to Patient/Credentials	Date

Processed by: _____ Date: _____ MR#: _____