

**RECORDS REQUESTED FROM OUTSIDE
ENTITY/FACILITY TO LSU HEALTHCARE NETWORK**

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)					
Patient Name:			Date of Birth:		
Address:			Social Security Number:		
City:			State/Zip Code:		
Entity/Provider Releasing PHI			Entity/Provider/Person Receiving PHI		
Name: _____			Name: LSU HEALTHCARE NETWORK		
Attention: _____			Attention: _____		
Phone: _____			Phone: _____		
Fax: _____			Fax: _____		
Delivery Method: <input type="checkbox"/> Email secure format <input type="checkbox"/> USPS Mail <input type="checkbox"/> Fax (Healthcare Provider only)					
Purpose of Disclosure					
<input type="checkbox"/> Establishing or Continuing care/Treatment					
Dates: From _____ To _____					
PHI and Dates of PHI Authorized for Use and Disclosure					
Description	Start Date	End Date			
Complete Health record					
Progress notes					
Laboratory tests					
History & Physical Examination					
Consultation reports					
Radiology films					
Itemized billing statement					
Other:					
<i>State and Federal laws protect the following information. If this information applies to you, please indicate if you would like the information released/obtained (indicate dates to be released where appropriate:</i>					
Alcohol, Drug, or Substance Abuse records	Dates:	Yes		No	
HIV Testing and Results	Dates:	Yes		No	
Mental Health	Dates:	Yes		No	
Psychiatry and Psychotherapy records	Dates:	Yes		No	
Signature of patient/personal/legal representative who may request disclosure:					
1. Any disclosure of information carries the potential for unauthorized RE-DISCLOSURE . Re-disclosed information may not be protected by federal confidentiality rules 2. I have the right to revoke this authorization at any time. Revocation does not apply to INFORMATION PREVIOUSLY/RELEASED 3. Treatment, payment, enrollment or eligibility is not a condition on whether I sign this authorization.					
DATE	SIGNATURE OF PATIENT/PARENT/CONSERVATOR/GUARDIAN	AUTHORITY/RELATIONSHIP TO PATIENT			