LSU Health
Healthcare Network

# 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:** ☐ **Email secure format** ☐ **USPS Mail** ☐ **Fax (Healthcare Provider only)**

**Purpose of Disclosure**

☐**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: | | |

***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:***

| | | | | | |
|---|---|---|---|---|---|
| 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 |
|---|---|---|
| | | |