AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification

Printed Name: ________________________________ Date of Birth: ____________________________

Address: ____

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Social Security # ________________________________ Telephone No.: ____________________________

Authority to Release Protected Health Information

I hereby authorize **EYE SPECIALISTS OF LOUISIANA, L.L.C.** to release the information identified in this authorization from the medical records of ____________________________(Patient's Name) and provide such information to ____.

Information to be Released – Covering the Periods of Health Care From (date) __________ to ____________

☐ **Complete Medical Record**

☐ **Partial Medical Record specifically to include:**

❑ History and Physical Exam	❑ X-ray Reports	❑ Itemized Bill
❑ Laboratory Test Results	❑ X-ray Films/Images	❑ Other (specify)
❑ Photographs & Videotapes	❑ Discharge Summary	
❑ Diagnosis & Treatment Codes	❑ Progress Notes	
❑ Consultation Reports	❑ Complete Billing Record	

Purpose of the Requested Disclosure of Protected Health Information - I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be "at the request of the individual"):________________________

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release - I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check One:*** **Yes** **No**

I understand if my medial or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. ***Check One:*** **Yes** **No**

Expiration Date -Unless revoked, this authorization will expire on the following date, or after the following time period or event: ____.

Right to Revoke Authorization - Except to the extent that action has already been taken in reliance on this authorization, this authorization may be revoked at any time by submitting a written notice to **EYE SPECIALISTS OF LOUISIANA, L.L.C.**, 7777 Hennessy Blvd. Suite 3001, Baton Rouge, Louisiana 70808.

Re-disclosure - I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure - I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party, I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. I hereby release and discharge **EYE SPECIALISTS OF LOUISIANA, L.L.C.**, its employees, agents and owners of any liability and the undersigned will hold them harmless for complying with this authorization.

Signature: ________________________________ **Date:** ____________________________

Description of Relationship if not patient:____