LAKESHORE UROLOGY

Authorization For Use And Disclosure Of Protected Health Information

PATIENT IDENTIFICATION:

Patient Name *(Print)*: _____ Dob: ____/____/____

Address: _____

Social Security #: _____ Telephone: _____

INFORMATION TO BE RELEASED, COVERING THE PERIODS OF HEALTH CARE:

From (Date): _____ to _____

From (Date): _____ to _____

PLEASE CHECK TYPE OF INFORMATION TO BE RELEASED:

_____ All Records
_____ Complete Health Record
_____ Pertinent Documentation
_____ History and Physical
_____ Progress Notes
_____ Consulting Reports
_____ Operative Report
_____ Discharge Summary
_____ Lab Results

_____ EKG
_____ EEG
_____ X-ray Reports
_____ X-ray Films/Images
_____ Photographs/Videotapes
_____Complete Billing File
_____ Itemized Bill
_____Other *(Specify)*: _____

PURPOSE OF REQUEST:

_____ Treatment or Consultation _____ At the Request of the Patient _____ Billing or Claims Payment

_____ All _____ Other *(Specify)* _____

I, THE UNDERSIGNED AUTHORIZE AND REQUEST LAKESHORE UROLOGY:

_____ **Release Information To** _____ **Obtain Information From**

Name: _____

Address:_____

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease. Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release.

TIME LIMIT & RIGHT TO REVOKE AUTHORIZATION

Except to the extent that action has already been taken in reliance on the authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 215 E Gibson Street, Covington, LA 70433 or 4315 Houma Blvd., Suite 302, Metairie, LA 70006. Unless revoked, this authorization will expire on the following date or event _____, or one year from the date of signature, unless otherwise specified.

Re-Disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclose. I understand that I do not have to sign the authorization or payment for services will be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I AUTHORIZE LAKESHORE UROLOGY TO USE AND DISCLOSE THE PROTECTED HEALTH INFORMATION SPECIFIED ABOVE.

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those records are protected by Federal Law. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibits information disclosed from records protected by this law from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Signature of Patient or Representative **Date**

_____ _____

Representative's Relation to Patient **Expiration Date of Authorization**

_____ _____

Signature of Witness **Date**