Authorization to Release or Obtain Health Information

(including paper, oral, and electronic information)

Name:______________________________________ Request Date:__________________

Address:____________________________________ Date of Birth:___________________

City/State/Zip:_______________________________ Social Security #:________________

I authorize:

Name: **Minden Family Care Center**

Address: 208 Morris Drive

City, State, Zip: Minden, LA 71055 Telephone: 318-377-8260 Fax: 318-377-9053

_____ **RELEASE Information TO** or _____ **OBTAIN Information FROM**

(Place an "X" on the line that indicates if the information is being released OR requested.)

Name: ____

Address: ____

City/State/Zip: _______________________________ Telephone #:____________________

The **Purpose of this Authorization** is indicated on the lines below. *(Place an "X" on the line(s) that apply.)*

___ Further Medical Care ___ Personal ___ Legal Investigation or Action ___ Changing Physicians
___ Research related treatment ___ Disclosure to a third party
___ Other: (Specify)____

I authorize the release of the following protected health information for dates ____________ to ____________

___ Entire Record ___ Medical History, Examination, Reports ___Surgical Reports ___ Prescriptions
___ Tests or Treatments ___ Immunizations ___ Laboratory Reports ___ X-ray Reports
___ Other:____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records:

___ Alcoholism ___ Drug Abuse ___ Mental Health ___ Vocational Rehabilitation ___HIV(Aids)
___ Sexually Transmitted Diseases ___Genetics ___ Psychotherapy Notes ___ Other:__________________

This authorization shall expire on ______________________________________(date or event).

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed.

______________________________________ ______________________

Signature of Individual or Personal Representative authorized by law Date

______________________________________ ______________________

Office Representative Date

Authorization of Release of Information to Family and/or Friends

Name of Patient: ______________________________ **Date of Birth:** __________

I authorize Minden Family Care Center to release protected health information to the entities names below:

Give information to spouse/partner: Yes No N/A

Name of spouse/partner: ______________________________

Give information to a family member or friend, please list:

Name	Relationship	Phone Number

Primary Patient Contact Number: ______________

Contact me at work: Yes No N/A
Leave message at work: Yes No N/A
Leave message at home: Yes No N/A

Description of Information to be released to family or friend:
Financial/Billing: Yes No
Medical Information: Yes No
Please list any restrictions regarding information to be released: ______________________

____

Rights of Patient:
I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed in the document by sending a written notification to Minden Family Care Center. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective immediately upon receipt of notification by this Practice. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representative signing this authorization:

______________________________________ Date: ____________
Signature of Patient or Personal Representative

____
Description of Personal Representative's Authority (attach necessary documentation)