AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

ST JAMES PARISH HOSPITAL
LARGE ENOUGH TO SERVE, SMALL ENOUGH TO CARE.

As required by the Health Insurance Portability and Accountability Act of 1996 St. James Parish Hospital may not disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein.

AUTHORIZATION SECTION:

I, _____ (print name), Date of Birth _____

Social Security Number _____ Address _____

Phone Number _____ _____

hereby authorize the use and disclosure of the following health information from _____ to _____

that pertains to me: ☐ Entire Medical Record ☐ Physician Progress Notes ☐ Laboratory Reports

☐ Radiology Reports/Images ☐ Other _____

The following information will be released when included in the above unless you indicate otherwise:

☐ Do not release any AIDS or HIV test results ☐ Do not release any records of genetic testing

For the purpose of: ☐ Treatment ☐ Insurance Payment ☐ Personal ☐ Legal Purposes ☐ Other _____

I authorize _____ to disclose my health information to the following person(s):

Name: _____

Address: _____

Email: _____ Phone: _____ Fax: _____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to St. James Parish Hospital. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. If I fail to specify an expiration date or event, I understand that this authorization will expire one year from signature date. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and obtain a copy of any information disclosed pursuant to this authorization.

_____ _____

Signature of Patient/ Legal Representative & Relationship Date

_____ _____

Witness for verbal consent Date

REVOCATION SECTION: You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to: St. James Parish Hospital, 1645 Lutcher Avenue, Lutcher, LA 70071.

I hereby revoke this authorization.

_____ _____

Signature of Patient/ Legal Representative & Relationship Date