Women's Healthcare Associates of Lafayette

Patient Name: _____ Date of Birth: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip: _____ Phone: _____

Information Released From:

Physician/Clinic Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Information Released To:

Name: Women's Healthcare Associates of Lafayette Phone: 337-534-0018

Address: 4630 Ambassador Caffery Pkwy, Suite 408, Lafayette, LA 70508 Fax: 337-889-3805

Medical Record Release:

Individually identifiable health information to be disclosed. Start date: _____ End date: _____

◊ Office visit/telephone notes	◊ Abstract/pertinent information
◊ Mammogram results	◊ Prenatal records
◊ Pap results	◊ Ultrasound
◊ Lab/Test results	◊ DEXA (Bone density)
◊ Hospital reports	◊ Other _____
◊ Operative procedure reports	◊ Entire medical record

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

- ◊ Treatment for alcohol and/or drug abuse (substance abuse)
- ◊ Mental Health (including psychotherapy notes)
- ◊ HIV related information (AIDS related testing)

Reason For Release:

◊ Consult/second opinion, personal	◊ Selected new physician
◊ Legal	◊ Referred by Dr/continuing care
◊ Insurance underwriting	◊ School
◊ Out of town move	◊ Other _____

- ❖ I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- ❖ I understand when my information is used or disclosed pursuant to this authorization it may be subject to redisclosure by the recipient and may no longer be protected by Federal HIPAA privacy rule.
- ❖ I understand that I may revoke this authorization at any time (provided such revocation is in writing to the providing organization's privacy official) except to the extent that the practice has acted in reliance upon this authorization.
- ❖ The consent will automatically expire in one year.
- ❖ I have a right to receive a copy of this form after I sign it.

I authorize the above provider to release the information marked above to the recipient.

Signed by: _____ Relationship to patient: _____

Patient's name: _____ Date: _____