

Authorization for Use and Disclosure of Protected Health Information

Print Patient Last Name _____ First _____ Middle _____
 Address _____ City _____ State _____ Zip _____
 Social Security Number _____ Date of Birth _____ Phone _____

I authorize Glenwood Regional Medical Center to disclose protected health information to:

Name _____ Phone/Fax Number _____
 Address _____ City _____ State _____ Zip _____
 Call this phone number when records are available for pick up at hospital _____

PURPOSE FOR USE/DISCLOSURE

Approximate date(s) of service to be used/disclosed _____

INFORMATION TO BE USED / DISCLOSED

- | | |
|---|--|
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Pathology report |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Lab reports |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Radiology reports/films |
| <input type="checkbox"/> Operative/procedure report | <input type="checkbox"/> EKG report(s) |
| <input type="checkbox"/> Consultation report(s) | |
| <input type="checkbox"/> Other _____ | |

Specific Authorization to Disclose Sensitive Records

I UNDERSTAND THAT THIS AUTHORIZATION IS TO INCLUDE USE / DISCLOSURE OF: (please check and initial)

- | | |
|---|---|
| <input type="checkbox"/> Alcohol and/or drug abuse records <i>Initials</i> _____ | <input type="checkbox"/> Psychiatric records <i>Initials</i> _____ |
| <input type="checkbox"/> Sexually transmitted disease information <i>Initials</i> _____ | <input type="checkbox"/> HIV/AIDS information <i>Initials</i> _____ |



*This information is disclosed from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is NOT sufficient for this purpose.

- I understand that I may revoke this authorization, in writing, at any time except to the extent that Glenwood Regional Medical Center has already relied on this authorization.
 - I understand that I may revoke this authorization by sending or faxing a written notice to the Privacy Officer, at Glenwood Regional Medical Center, 503 McMillan Road, West Monroe, LA 71291 or fax 318-329-4435, stating my intent to revoke this authorization.
 - Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is one year after signing and dating this form, unless otherwise documented here: _____
 - I understand that Glenwood Regional Medical Center may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization form.
 - I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the Federal privacy law, if the recipient is not a "covered entity".
- If box is checked, the hospital will receive direct or indirect financial compensation in connection with the use or disclosure of your information for marketing purposes.

Signature (Patient or Patient's Legal Representative) _____ Date _____

Printed Name of Legal Representative _____ Relationship to Patient _____

PLEASE NOTE: THIS FORM MUST BE COMPETED IN ITS ENTIRETY. THANK YOU FOR YOUR COMPLIANCE.

	Account Number: _____		MR Number: _____						
	Patient Name: _____								
	Admit Date: _____								
 503 Mcmillan Rd. - West Monroe, LA 71291	DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC
	Allergies: _____								
	Attending Physician Name: _____								