# The Center for Pediatric and Adolescent Medicine

## Authorization to Release or Obtain Health Information

**(Including paper, oral and electronic information)**

***Pursuant to 45 CFR sec 164.508(6)**

**Patient Information:**

| | |
|---|---|
| **Name:** | **Request Date:** |
| **Mailing Address:** | **Date of Birth:** |
| **City/State/Zip:** | **Medicaid or Social Security #** |

**I authorize:**

Name: _____

Mailing Address: _____

City/State/Zip: _____

Relationship: _____ Telephone Number: _____

Fax Number: _____

▫ **To RELEASE Information TO** **OR** ▫ **To OBTAIN Information FROM**

*(Place an "X" in the box that indicates if the information is being released or requested.)*

Name: _____

Mailing Address: _____

City/State/Zip: _____

Relationship: _____ Telephone Number: _____

Fax Number: _____

The **Purpose of this Authorization** is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)

▫ Further Medical Care ▫ Personal ▫ Legal Investigation or Action ▫ Changing Physician(s)

▫ Research related treatment ▫ Creating health information for disclosure to a third party

▫ Other: (Specify)_____

**I authorize the release of the following protected health information:**

(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

▫ Entire Record ▫ Medical History, Examination, Reports ▫ Surgical Reports ▫ Treatment or Tests

▫ Prescriptions ▫ Immunizations ▫ Hospital Records including Reports ▫ Laboratory Reports

▫ X-ray Reports ▫ MR/DD Records ▫ Other: (Specify)_____

**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: (Specify)_____

**This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.**

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. **I acknowledge that I have read both pages 1 and 2 of this form**.

_____ _____

**Signature of individual or Personal Representative Authorized by Law** **Date**

_____

_____ _____

**Signature of Witness (If signed with an "X" or mark)** **Date**

**† Provider shall be given a copy of signed document that acknowledges their receipt of Federal Rule 42 CFR § 2.32 – Prohibition on redisclosure.**

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## My Rights:

- **I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, enrollment, or eligibility). However, I do have to sign an additional authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.**
- **I may revoke this authorization in writing by sending a letter to the healthcare provider to whom the authorization is directed. If I did, it would not affect any actions already taken by the healthcare provider based upon this authorization.**
- **I may not be able to revoke this authorization if its purpose was to obtain insurance.**
- **I understand that once the healthcare provider discloses my health information, the person or entity that receives it, may re-disclose it. The HIPAA Privacy laws may no longer protect it.**

**CPAM Thibodaux Location:**

**604 N. Acadia Road, Suite 200**
**Thibodaux, LA 70301**
**Ph# (985) 448-3700**
**Fax# (985) 448-3900**

**CPAM Houma Location:**

**5040 West Main Street, Suite 1**
**Houma, LA 70360**
**Ph# (985) 851-2000**
**Fax# (985) 876-1787**

**Office Use Only:**

**Received by: (initials)_____**
**Date Received: _____**