LOUISIANA WOMEN'S Healthcare | Ochsner

500 RUE DE LA VIE, SUITE 100 • BATON ROUGE, LOUISIANA 70817 • 225-201-2000

Release of Protected Health Information

Patient Name: _____ Date of Birth:_____

Previous Name: _____ Account #_____

I. Authorization

☐ For _____to disclose my health care information to

Dr. _____Fax: _____ at Louisiana Women's Healthcare.

☐ For Louisiana Women's Healthcare to disclose my health care information to:

Name: _____

Address: _____

_____

Phone: _____ Fax:_____

II. You may use or disclose the following health care information:

☐ Entire Content of Record

☐ Entire Content of Record (excluding STDs, HIV, behavioral health, mental health genetic/genomic information or treatment for alcohol and drug abuse).

☐ Only the Following Content (specify)

_____

IV. Purpose of this authorization:

☐ At my request

☐ Relocation

☐ For Insurance Change

☐ Other: _____

☐ Check here only when Louisiana Women's Healthcare Associates requests the authorization for marketing purposes

☐ Check here only when Louisiana Women's Healthcare Associates will get something of value for providing health information for marketing purposes

V. This authorization ends:

☐ On (date) _____

☐ When the following event occurs _____

VI. My Rights:

- I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility). However, I do have to sign an 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 health care provider to whom the authorization is directed. If I did, it would not affect any actions already taken by the health care 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 health care 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.

****This request form can be mailed or faxed to Louisiana Women's Healthcare.**

_____ _____

Patient Signature Date

_____ _____

Individual legally authorized to sign on behalf of the patient Relationship to patient