BONE & JOINT
CLINIC OF BATON ROUGE

MEDICAL RECORDS DEPARTMENT
P.O. Box 98035 • Baton Rouge, LA 70898
Phone: 225-766-0050 ext. 5001
Direct Fax: 225-819-5098
medicalrecords@bjcbr.com

AUTHORIZATION FOR RELEASE OF PHI (PROTECTED HEALTH INFORMATION)

INSTRUCTIONS FOR FILLING OUT FORM:

This form allows for your health information to be sent to another doctor, your employer, an insurance company, a law office, etc. **Failure to fill out ALL parts of the form as described below will result in delays in your request, as it will have to be returned to you for completion.**

- **PATIENT IDENTIFICATION:** Please fill in all information.
- **AUTHORITY TO RELEASE PROTECTED HEALTH INFO:** Write the name and contact information (phone, fax, address) of the person you would like your records to be sent.
- I**NFORMATION TO BE RELEASED:** Please check either the complete record or partial record (if you choose partial, please specify treatment dates and which parts of your records are to be sent).
- **THE PURPOSE FOR DISCLOSURE:** Please check one.
- **EXPIRATION DATE:** The authorization must have an expiration date. N/A is not acceptable. Please either choose a date (many people choose one year from today) or an event (end of litigation, action taken, etc.)
- **DRUG AND/OR ALCOHOL ABUSE:** Please check yes or no for both questions.
- **SIGNATURE:** Please sign and date at the bottom of the form.
- **SUBMIT COMPLETED DOCUMENT:** Once finished, return the completed form to the medical records department by coming to the clinic at any time during normal business hours. If it isn't convenient for you to come to the clinic, you can print the request form and return it to the medical records department via mail, fax, or email.

PLEASE NOTE: Requests are processed in the order received. While we strive to process requests in the quickest timeframe possible, it may take up to fifteen (15) days before we are able to get to your request (pursuant to LA R.S. 40:1299.96.). If you have any questions or if we can be of any assistance, please do not hesitate to contact us!

Thank you,
Medical Records Department

AUTHORIZATION FOR RELEASE OF PHI (PROTECTED HEALTH INFORMATION)

PATIENT IDENTIFICATION:

Printed Name: _____ Date of Birth: _____

Address: _____

_____

Social Security #: _____ Telephone #: _____

AUTHORITY TO RELEASE PROTECTED HEALTH INFO:

I hereby authorize Bone and Joint Clinic of Baton Rouge, Inc. to release the information identified in the authorization from the medical records of the above-named patient and provide such information to:

Name: _____

Address: _____

Phone and/or Fax #: _____

INFORMATION TO BE RELEASED (choose one below):

☐ Complete Medical Record (including itemized billing) covering any and all periods of treatment from birth to the present date.

☐ Partial Medical Record, covering the periods of health care from _____ to _____

- ☐ History and Physical Exam
- ☐ Laboratory Test Results
- ☐ Photographs and Videos
- ☐ Diagnosis and Treatment Codes
- ☐ Consultation Reports
- ☐ X-ray Reports
- ☐ X-ray Films/Images
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Complete Billing Record
- ☐ Other (specify) _____

THE PURPOSE FOR DISCLOSURE:

I am authorizing the release of my Protected Health Information for the following purpose:

☐ at the request of the individual ☐ treatment with another doctor ☐ legal ☐ claim ☐ other (specify) _____

EXPIRATION DATE:

Unless revoked, this authorization will expire on the following date or after the following time period or event:

_____

DRUG/ALCOHOL ABUSE, HIV/AIDS, PSYCHIATRIC RECORDS RELEASE:

☐ yes ☐ no I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release.

☐ yes ☐ no I also understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

RIGHT TO REVOKE AUTHORIZATION: Except to the extent that action has already been taken in reliance on this authorization, this authorization may be revoked at any time by submitting a written notice to Bone and Joint Clinic of Baton Rouge, Inc. Attn: Medical Records Dept. 7301 Hennessy Blvd., Suite 200 Baton Rouge, LA 70808.

RE-DISCLOSURE: I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE: I understand that I do not have to sign this authorization, and my treatment of payment for services will not be denied if I do not sign this form. However, if healthcare services are being provided to me for the purpose of providing information to a third party, I understand that services may be denied if I do not authorize the release of information related to such healthcare services to the third party. I can inspect or copy the protected health information to be used or disclosed. I hereby release and discharge Bone and Joint Clinic of Baton Rouge, Inc., its employees, agents, and owners of any liability and the undersigned will hold them harmless for complying with this authorization.

SIGNATURE: _____ **DATE:** _____

Name and relationship of person completing this form: _____