

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name (Last, First, Middle)		Date of Birth	Clinic #
Address			
City		State	Zip
Provider Authorized to Release the PHI	Name and Address		Phone
Recipient of the Health Information	Name and Address		Phone
	Attention:		
Purpose of this disclosure:			
Authorization expiration date or event: (If date or event is not indicated, authorization will expire 12 months from date signed.)			

Check items of health information to be released under this authorization.							
	Description of information	Start date	End date		Description of information	Start date	End date
<input type="radio"/>	Laboratory tests			<input type="radio"/>	Ultrasound		
<input type="radio"/>	EKGs			<input type="radio"/>	Nuclear		
<input type="radio"/>	Stress test/treadmills			<input type="radio"/>	Procedure/cath reports		
<input type="radio"/>	Echo			<input type="radio"/>	H&P, progress note, event note		
<input type="radio"/>	Other: <i>(please specify)</i>						

The following information will be released when included in the above unless you indicate otherwise . Do not release:			
<input type="radio"/>	AIDS or HIV test results	<input type="radio"/>	Psychiatric care or mental health
<input type="radio"/>	Alcohol/substance abuse treatment	<input type="radio"/>	Other: <i>(please specify)</i>
If checked, this is a conditional authorization, and you will not receive the following services unless you sign this authorization. (Describe any consequences of refusing to sign):			

- I understand that if the person or entity receiving this information is not a health plan or health care provider covered by federal privacy regulation, the released information may not be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying CIS in writing and mailing to CIS Privacy Officer, PO Box 3812, Houma, LA 70361. However, if I choose to do so, I understand that my revocation will not affect any actions taken by CIS before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
- I understand that CIS may require me to sign an authorization prior to receiving research-related treatment or for treatment solely for the purpose of creating health information for another party.
- I have a right to receive a copy of this form after I sign it.

Signature of Patient:	Date:
Signature of Patient Representative (if necessary):	
Personal Representative's Relationship to Patient: (see below)	

(1.) The judicially appointed tutor or curator of the patient, if one has been appointed. (2.) An agent acting pursuant to a valid mandate, specifically authorizing the agent to make health care decisions. (3.) The patient's spouse not judicially separated. (4.) An adult child of the patient. (5.) Any parent, whether adult or minor, for his minor child. (6.) The patient's sibling. (7.) The patient's other ascendants or descendants. (8.) Any person temporarily standing in loco parentis, whether formally serving or not, for the minor under his care and any guardian for his ward. (9.) Other (please specify).