AUTHORIZATION TO
RELEASE PROTECTED
HEALTH INFORMATION (PHI)
TO/FROM JPHSA

**Note**: All applicable fields must be completed



RELEASE INFORMATION FROM/IN THE CUSTODY OF RELEASE INFORMATION TO  Name/Facility:		
Name/Facility:	Name of Patient:	Date of Birth:
Address:	RELEASE INFORMATION FROM/IN THE CUSTODY O	F RELEASE INFORMATION TO
Address:	Name/Facility:	Name/Facility:
Phone/Fax:		Address:
PRIENTIAL BRAILE		
PURPOSE OF RELEASE (Please select at least one.)    Patient is Moving   New Home Address:		Pnone/Fax:
Patient is Moving   New Home Address:		Ellidii.
New Home Address: New Provider/Practice (Last five (5) years unless otherwise specified) Personal Disability Determination Other: Legal Purposes Insurance Purposes Treatment Workers' Comp Claim  INFORMATION TO BE RELEASED (Please select all that apply.) Last Vears/months/days) of Medical/Treatment/Service Records History and Physical Lospital Records Bail Hospital Hospital Records Bail Hospital Hospit		
Transfer of Care to New Provider/Practice (Last five (5) years unless otherwise specified) Personal   Disability Determination   Other:	•	New Phone:
Personal   Disability Determination   Other:   Legal Purposes   Insurance Purposes   Insurance Purposes   Treatment   Workers' Comp Claim    INFORMATION TO BE RELEASED (Please select all that apply.)  Last   (years/months/days) of Medical/Treatment/Service Records   History and Physical   Lab/Pathology Reports   Radiology Reports   Radiology Reports   Payment/Claim Records   Diagnostic Reports   Diagnostic Reports   Diagnostic Reports   Progress Reports   Other (please specify)    SENSITIVE INFORMATION TO BE RELEASED   Understand that the information to be released may contain sensitive information. I authorize the release of information unless I have checked any of the boxes below indicating otherwise:   IDO authorize the release of information derived from services by a mental health professional.   IDO NOT authorize I want to review such mental health information before it is sent.   IDO authorize release of information regarding HIV infection status.   IDO NOT authorize IDO authorize release of Progress Notes (provider documentation of Medication Management)   IDO NOT authorize IDO authorize release of Therapy Notes (notes documenting/analyzing conversations during therapy)   IDO NOT authorize the release of information review from a substance use disorder treatment facility/program.   IDO NOT authorize IDO authorize release of Therapy Notes (notes documenting/analyzing conversations during therapy)   IDO NOT authorize IDO authorize release of Therapy Notes (notes documenting/analyzing conversations during therapy)   IDO NOT authorize the release of information revocation of this authorization are included in the facility's notice of privacy practices. Revocation must be made in writing to the facility releasing the information. Information released pursuant to this authorization may be subject to rerelease by the recipient and may no longer be protected by federal or state law. A copy of this authorization is available on request. Jefferson Parish Human Services Authority and its programs (JPHSA) will not		
Legal Purposes   Insurance Purposes   Workers' Comp Claim		
Treatment   Workers' Comp Claim		·
Last		·
Last	INFORMATION TO BE RELEASED (Please select all ti	hat annly.)
Hospital Records   Lab/Pathology Reports   Payment/Claim Records   Diagnostic Reports   Diagnostic Reports   Diagnostic Reports   Diagnostic Reports   Other (please specify)   Progress Reports   Diagnostic Reports   Diagnostic Reports   Diagnostic Reports   Diagnostic Reports   Other (please specify)   Progress Reports   Diagnostic Reports   D		
Payment/Claim Records   Radiology Reports   Diagnostic Reports   Diagnostic Reports   Consultation Reports   Progress Reports   Other (please specify)   Progress Reports   Other (please specify)   Progress Reports   Progress Reports   Other (please specify)   Progress Reports   Other (please specify)   Progress Reports   Progress I have checked any of the boxes below indicating otherwise:   I DO authorize the release of information derived from services by a mental health professional.   I DO NOT authorize   Progress Reports   I DO Authorize the release of information derived from services by a mental health professional.   I DO NOT authorize   I DO authorize release of information regarding HIV infection status.   I DO NOT authorize   I DO Authorize release of Progress Notes (provider documentation of Medication Management)   I DO NOT authorize   I DO Authorize release of Therapy Notes (notes documenting/analyzing conversations during therapy)   I DO NOT authorize   I DO Authorize release of Therapy Notes (notes documenting/analyzing conversations during therapy)   I DO NOT authorize   I DO Authorize release of the revoked at any time except to the extent any person has taken action in reliance upon this authorization. Further details on revocation of this authorization are included in the facility's notice of privacy practices. Revocation must be made in writing to the facility releasing the information. Information released pursuant to this authorization is available on request. Jefferson Parish Human Services Authority and its programs (JPHSA) will not condition treatment on the signing of this authorization. I understand that I may refuse to sign this authorization. This authorization expires 12 months from the date of my sign		
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Printed Name of Person Signing (it not patient):	Printed Name of Person Signing (if not patient):	

**Relationship to Patient (if not patient):** □ Parent □ Legal Guardian/Conservator\* □ Health Care Power of Attorney\*

\*Copy of court order or Power of Attorney required