

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

Note: All applicable fields must be completed



Name of Patient: _____

Date of Birth: _____

RELEASE INFORMATION FROM/IN THE CUSTODY OF

RELEASE INFORMATION TO

Name/Facility: _____

Name/Facility: _____

Address: _____

Address: _____

Phone/Fax: _____

Phone/Fax: _____

Email: _____

Email: _____

PURPOSE OF RELEASE (Please select at least one.)

Patient is Moving

New Home Address: _____

New Phone: _____

Transfer of Care to 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 _____ (years/months/days) of Medical/Treatment/Service Records

History and Physical

Hospital Records

Lab/Pathology Reports

Payment/Claim Records

Radiology Reports

Immunization Records

Diagnostic Reports

Consultation Reports

Progress Reports

Other (please specify) _____

SENSITIVE INFORMATION TO BE RELEASED

I 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:

I DO authorize the release of information derived from services by a **mental health** professional.

I DO NOT authorize.

I want to review such mental health information before it is sent.

I DO authorize the release of information regarding **HIV** infection status.

I DO NOT authorize.

I DO authorize release of information derived from a substance use disorder treatment facility/program.

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.

This authorization may be 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 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 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 signature below. During the 12-month period, JPHSA/JeffCare may make subsequent disclosures to the recipient named above.

I, the undersigned, hereby authorize the release of the protected health information described above subject to the restrictions described above:

Signature: _____

Date: _____

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