AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION (PHI)
Two-Way

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

JPHSA
JEFFERSON PARISH HUMAN SERVICES AUTHORITY

Name of Patient: _____ **Date of Birth**: _____

RELEASE INFORMATION TO/FROM

Name/Facility: _____
Address: _____
_____
Phone/Fax: _____
Email: _____

RELEASE INFORMATION TO/FROM

Name/Facility: _____
Address: _____
_____
Phone/Fax: _____
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
☐ Hospital Records
☐ Payment/Claim Records
☐ Immunization Records
☐ Consultation Reports
☐ History and Physical
☐ Lab/Pathology Reports
☐ Radiology Reports
☐ Diagnostic 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*