FRANCISCAN MISSIONARIES OF OUR LADY HEALTH SYSTEM

Authorization for Release of Protected Health Information (PHI)

Patient's Name/Address/Phone		
Requester's Name/Relationship to Patient:	Birth Date:	Last 4 of Social Security #
Provider's Name/Address:		

This authorization shall expire on this expiration date _____
** If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed

Purpose of Disclosure ☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other

Method of Delivery ☐ Paper ☐ CD ☐ Secure Email Email Address:_____

Description of Information to be used or disclosed.

Is this request for psychotherapy notes?
☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.
☐ No, then you may check as many items below as you need

Information to be disclosed:

☐ Discharge Summary	☐ History & Physical Exam	☐ Operative Report	☐ EKG
☐ ER Record	☐ Laboratory Report	☐ Radiology Images	☐ Itemized Bill
☐ Pathology Report	☐ Consultation	☐ Radiology Reports	☐ Other:_____

Date of Service: _____ to _____

The information is to be released to:

_____
(facility name) (address) (city) (state) (zip)

The information is to be released from:

_____
(facility name) (address) (city) (state) (zip)

The following information will be released when included in the above unless you indicate otherwise:
☐ Do not release any AIDS or HIV test results ☐ Do not release any records of psychiatric care
☐ Do not release any records of alcohol/drug abuse ☐ Do not release records of genetic testing

1. I understand that this authorization is voluntary and that I may refuse to sign per the Health Insurance Portability and Accountability Act (HIPAA). Louisiana law requires a written authorization in order to release protected health information.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released may no longer be protected by federal regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may get a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient or Legal Representative:	Date/Time:
Print Name of Patient or Legal Representative:	Relationship to Patient or Legal Representative:

OUR LADY OF LOURDES
4801 Ambassador Caffery Pkwy
Lafayette, LA 70508
337 470-2136 (phone)
337 470-2682 (fax)

OUR LADY OF THE LAKE
5000 Hennessy Blvd.
Baton Rouge, LA 70808
225-765-8541(phone)
225-765-1200 (fax)

OUR LADY OF THE LAKE ASCENSION
1125 West Hwy 30
Gonzales, LA
225-647-5088 (phone)
225-743-2329 (fax)

ST. FRANCIS MEDICAL CENTER
309 Jackson Street
Monroe, LA 71201
318-966-4754 (phone)
318-966-4757 (fax)

OUR LADY OF THE ANGELS HOSPITAL
433 Plaza Street
Bogalusa, LA 70427
985-730-2255 (phone)
985-730-7138 (fax)

LOURDES WOMEN'S & CHILDREN'S HOSPITAL
4600 Ambassador Caffery Parkway
Lafayette, LA 70508
337-521-9350 (phone)
337-521-9124 (fax)

OLOL CHILDREN'S HOSPITAL
8300 Constantin Blvd
Baton Rouge, LA 70809
225 374-1345 (phone)
225 374-1625 (fax)

HEART HOSPITAL OF LAFAYETTE
1105 Kaliste Saloom Road
Lafayette, LA 70508
337-470-1313 (phone)
337-470-1320 (fax)