Natchitoches Regional Medical Center

Inspiring Excellence Everyday

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

_____

Social Security #: _____ Telephone: (_____)_____

Dates of Service for Information To Be Released

From (date) _____ to (date) _____

Please check type of information to be released:

□ Complete health record	□ Discharge summary	□ X-ray reports or Lab Results
□ History and physical exam	□ Consultation reports	□ Progress notes

□ Other, (specify) _____

Purpose of Request

□ Treatment or consultation	□ At the request of the patient	□ Billing or claims payment

□ Other (specify) _____

Who and Where to Send / Release Information

Name: _____

Address: _____

_____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Natchitoches Parish Hospital, P. O. Box 2009, Natchitoches, LA 71457. Unless revoked, this authorization will expire on the following date or event or 180 days from the date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize Natchitoches Regional Medical Center to release the protected health information specified above.

Signature: _____Date: _____

Authority to Sign if not patient: _____

Identity of Requester Verified via**:** □ Photo ID □ Matching Signature □ Other, specify

Verified by: _____