WEST FELICIANA PARISH HOSPITAL
5266 Commerce Street, P.O. Box 368
Saint Francisville, Louisiana 70775
Phone: 225-635-3811 Fax: 225-635-2435

For Office Use:
Release Processed by:______________________
Date:_____________________________________
Number:__________________________________

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name____ Date of Birth__________________________

Address___________________________________ City, State, Zip Code______________________________________

I hereby authorize West Feliciana Parish Hospital to release the information identified in this authorization form from the medical records of _______________________________ (Patient's Name) and provide such information to ____.

Information to be Released - Covering the Periods of Healthcare from _____________________________(date) to __________________________ (date).

Please check information to be released:

☐ Complete health record	☐ Diagnosis and Treatment Codes	☐ Discharge Summary
☐ History and Physical Exam	☐ Consultation Reports	☐ Progress Notes
☐ Laboratory test results	☐ X-ray Reports	☐ X-ray films/images
☐ Photographs, videotapes	☐ Complete billing record	☐ Itemized bill

☐ Other (specify) ____

Purpose for Release: ☐ Medical ☐ Legal ☐ Insurance ☐ Other_______________________________________

The patient's expresses authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information, HIV testing and treatment, and psychiatric treatment. To authorize release of this information, please read and sign the following:

I,________________________________ authorize the release of **alcohol and/or drug abuse** treatment and information.
I,________________________________ authorize the release of **HIV/AIDS test results** and/or HIV/AIDS treatment information.
I,________________________________ authorize the release of **psychiatric** information.

RIGHT TO REVOKE AUTHORIZATION
Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to West Feliciana Parish Hospital at St. Francisville, LA. Unless revoked, this authorization will expire on the following date after ninety (90) days.

REDISCLOSURE
I understand the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

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. However, if health care services are provided to me for the purpose of providing information to a third party (e.g., fitness-for-work), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. **I hereby release and discharge West Feliciana Parish Hospital of any liability and the undersigned will hold West Feliciana Parish Hospital harmless for complying with this Authorization.**

Signature:____Date__________________________________

Description of relationship, if not patient:____