LOUISIANA CARDIOVASCULAR & THORACIC INSTITUTE, LLC
Healing Cenla one heartbeat at a time.

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Gary P. Jones, MD, FACS
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Authorization for Release of Protected Health Information

Patient Identification

Printed Name: _____ Date of Birth: _____

Previous Name: _____

Authorization Louisiana CardioVascular & Thoracic Institute, LLC to disclose my health care information.

You may use or disclose this health information to:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Please check type of information to be released:

☐ Complete health record	☐ Diagnosis & 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 of the Requested Disclosure of Protected Health Information

□ At my request

□ Other: _____

This authorization ends:

□ On (date) _____

□ When the following event occurs _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check One:*** ☐ **Yes** ☐ **No**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. ***Check One:*** ☐ **Yes** ☐ **No**

Signature of Patient or Personal Representative Who May Request Disclosure

*I understand that I do not have to sign this authorization in order to get healthcare (treatment, payment, enrollment, or eligibility). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party (e.g. fitness-for-work test),
*I may revoke this authorization in writing by sending a letter to a health care provider to whom the authorization is directed. If I did, it would not affect any actions already taken by the health care provider based upon this authorization.
*I may not be able to revoke this authorization if its purpose was to obtain insurance.
*I understand that once the healthcare provider discloses my health information, the person or entity that receives it, may re-disclose it. The HIPAA Privacy laws may no longer protect it.

Signature: _____ Date: _____

Signature of Patient or Legal Guardian: _____

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