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Gary P. Jones, MD, FACS

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:

| | | |
|--|--|---|
| <input type="checkbox"/> Complete health record | <input type="checkbox"/> Diagnosis & treatment codes | <input type="checkbox"/> Discharge summary |
| <input type="checkbox"/> History and physical exam | <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Progress notes |
| <input type="checkbox"/> Laboratory test results | <input type="checkbox"/> X-ray reports | <input type="checkbox"/> X-ray films / images |
| <input type="checkbox"/> Photographs, videotapes | <input type="checkbox"/> Complete billing record | <input type="checkbox"/> 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: _____