SMH
Your Hospital for Life.

AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION (PHI)

I authorize Slidell Memorial Hospital and the physicians who treated
Name of facility disclosing records

_____ _____ _____
Full legal name of patient | Patient's date of birth | Patient's Social Security #

to release to: _____
Specific name of hospital, physician, service agency or third party

_____
Address | City | State | Zip

Telephone #: _____ Fax #: _____

for the purpose of: _____ the following information from my medical record:
Specific reason

- ◯ Discharge Summary
- ◯ History & Physical
- ◯ Operative Report
- ◯ Emergency Room Record
- ◯ Lab Reports
- ◯ X-ray Reports
- ◯ Other - please specify:

_____

To include:

- ◯ Genetic testing information
- ◯ Alcohol and/or drug abuse information
  (Confidentiality of drug/alcohol abuse records are protected by Fed. Reg. 42 CFR Part 2)
- ◯ HIV - related information
  Any information that is likely to identify, directly or indirectly, someone as having been tested for, or actually having HIV infection, antibodies to HIV, AIDS, or related infections or illnesses, or someone suspected of having HIV as a result of high-risk activities).
  PATIENT DOES NOT HAVE TO AUTHORIZE RELEASE OF HIV-RELATED INFORMATION.*
- ◯ Mental Health records (Does not include psychotherapy notes)

Date(s)/Type of Service: _____

Redisclosure: I understand that, if the person or entity receiving the information is not a health-care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements (Fed. Reg. 42 C.F.R. Part 2).

Revocation/Expiration: I understand that I may revoke this authorization by notifying, in writing, the Medical Record Department, knowing that previously disclosed information would not be subject to my revoke request. In any event, it will expire 365 days from this date, unless sooner revoked.

Refusal to sign: I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

Patient's right to inspect/obtain copy: The patient has a right to inspect and/or obtain a copy of the PHI to be used and/or disclosed. Fee for copies shall not exceed the amount defined by Louisiana law. Fee schedule is available in the Medical Record Department.

Compensation: Unless otherwise indicated, the disclosure and use of PHI noted above will not result in compensation to Slidell Memorial Hospital from a third party.

◯ Slidell Memorial Hospital will receive compensation for disclosure/use of above noted PHI

Signed: _____ Date: _____
Patient (or legally authorized representative)

Print name of patient or legal representative: _____

Relationship to patient: _____

Witness: _____ Date: _____

* ◯ **I DO NOT** authorize release of HIV-related information.
(A copy of this authorization will serve as the original.)