East Jefferson Family Practice

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Patient's Date of Birth: _____

Patient's SSN: _____

☐ To receive from ☐ To release to:

Name: _____

Address: _____

Phone: _____ Fax: _____

I authorize the release of any records in regards to:

_____Complete Medical Records _____Medication List

_____Lab Reports _____Radiology Reports

_____Operative Reports/Notes _____Substance Abuse/Drug Related Records

_____Other:_____

For Dates of Service: _____

I authorize the release of HIV results. I understand I am authorized by law to allow or to refuse the release of HIV Test Results. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone:

☐ I authorize the release of HIV test results
☐ I do not authorize the release of HIV test results

- I understand that this authorization will expire on_____
- I understand that I may revoke this authorization (except to the action was already taken in reliance on this signed authorization).
- I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits.
- I may inspect or copy any information used or disclosed under this agreement.
- I understand that if the person or organization that receives the information is not a health care provider plan covered by federal privacy regulations, the information describe above may be re-disclosed and would no longer be protected by these regulations.

_____

Signature of Patient/ Representative Date:

3848 Veterans Blvd Ste. 101 Metairie, LA 70002 Ph: 504-885-2505 Fax: 1-281-817-5509

2109 David Drive Metairie, LA 70003 Ph: 504-885-2505 Fax: 1-281-817-5509

Dr. Alex Hoang Dr. Dung Tran Dr. Charlie Le Dr. Tai Nguyen