HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

As required by HIPAA (Health Information Portability and Accountability Act) of 1996 Fertility and Women's Health Center of Louisiana, LLC may not use or disclose your health information except as provided in our Notice of Privacy Policy without your authorization. Your signature on this form indicates that you are giving permission for the use and disclosure described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

PATIENT NAME ____________________

DATE OF BIRTH ____________ SS# ____________ ACCOUNT ____________

ADDRESS ____________________

CITY ____________ STATE ________ ZIP ________ DAY PHONE ____________

I hereby authorize ____________________ to release information from my medical record as indicated below to:

NAME **Fertility & Women's Health Center of Louisiana**

ADDRESS **206 E. Farrel Rd.**

CITY **Lafayette** STATE **LA** ZIP **70508** FAX **337-989-8766**

INFORMATION TO BE RELEASED:	**DATES:**
☐ HISTORY AND PHYSICAL EXAM	________
☐ PROGRESS NOTES	________
☐ LAB REPORTS	________
☐ X-RAY AND U/S REPORTS	________
☐ OTHER: ____________	________

PURPOSE OF DISCLOSURE:

☐ LEGAL	☐ CHANGING PHYSICIANS	☐ CONTINUING CARE
☐ SCHOOL	☐ CONSULTATION/SECOND OPINION	☐ INSURANCE PURPOSE
☐ RESEARCH	☐ OTHER ____________	

1. I understand that this authorization will expire on ____________________.
2. I understand that I may revoke this authorization at any time by notifying Fertility & Women's Health Center of LA in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release information by Fertility & Women's Health Center of LA for the purpose of: ____________________

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   a. by authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand that I may see and copy the information described on this form if I ask for it, and I will get a copy of this form after I sign it.
   c. I understand that in compliance with Louisiana statute, I will pay a fee of $____________. There is no charge for medical records if copies are sent to facility for ongoing care or follow-up treatment.

____________________ PRINT PATIENT NAME

____________________ DATE

____________________ SIGNATURE OF PATIENT

____________________ SIGNATURE OF PARENT/LEGAL GUARDIAN

____________________ WITNESS