# Musculoskeletal Institute of Louisiana

**Orthopedic Specialists of Louisiana • Pain Care Consultants • Electrodiagnostic Medicine**

## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize Musculoskeletal Institute of Louisiana to use or disclose the following protected health information (PHI) from the medical records of the patient listed below:

Patient Name: _____ DOB: _____

Patient Address: _____

Home Phone: _____ Work: _____ Mobile: _____

☐ I will pick up copies of my records ☐ Mail copies of my records to the individual noted below

☐ Fax my records to: _____ ☐ Provide my records in electronic form

| Information is to be disclosed by | And is to be provided to: |
|---|---|
| Name: | Name: |
| Address: | Address: |
| Phone: | Phone: |
| Fax: | Fax: |

**Purpose of request**: ☐ Patient's Request ☐ Dispute ☐ Legal ☐ Referral ☐ Other: _____

**Information to be disclosed from my health record:** *(check appropriate box(es))*

☐ Only the period of events from _____ to _____

☐ Recent Progress Notes ☐ Pathology/ Lab Reports ☐ X-Ray Reports/Films

☐ Billing Records ☐ Operative Report ☐ Entire Health Record *(Excludes Psychotherapy Notes)

☐ Other: _____

**If you would like any of the following sensitive information disclosed, check the applicable box(es) below:**

☐ Alcohol/Drug Abuse Treatment Referral ☐ HIV/AIDS-related Treatment

☐ Mental Health *(Other than Psychotherapy Notes)*

☐ Psychotherapy Notes (If Checking this box, no other boxes may be checked. A separate Authorization to Release/Request for an individual's Health Information must be completed to obtain additional records.)

**I understand (Please Initial):**

____ I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original

____ I have the right to revoke this Authorization in writing at any time to Musculoskeletal Institute of Louisiana and the revocation will not apply to information already retained, used, or disclosed in response to this Authorization.

____ **In order to release sensitive information regarding Alcohol/Drug Abuse Treatment/Referral, HIV/AIDS-Related Treatment, Mental Health (other than psychotherapy notes), I must check the appropriate box or boxes. In order to authorize the use or disclosure of Psychotherapy Notes I must only check this specific box on this form. Authorizations for the use or disclosure of other health record information may not be made in conjunction with authorizations pertaining to Psychotherapy Notes. If this box is checked with other boxes, another authorization will be required to authorize the use or disclosure of Psychotherapy Notes Only.**

____ My health care and payment for my health care will not be affected if I do not sign this form.

____ The information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

**By signing below, I acknowledge that I have read and understand this Authorization** (*a copy of the signed form will be given to you)*

_____ _____ _____

Signature of Patient, Parent or Legal Representative Relationship to Patient Date

Effective Date: October 1, 2001
Reviewed/Revised Date: May 31, 2013