ACADIANA WOMEN'S HEALTH GROUP, APMC
4640 AMBASSADOR CAFFERY PARKWAY
LAFAYETTE, LA 70508
337-984-1050/FAX-337-984-8776

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient: Name____ Date of Birth__________________

Address:_______________________________ __ ___________Social Security #:__________________

City__________________________________ State _____ Zip____________ Day Phone #:______________

Information released from:
Physician/Clinic
name:____Phone__________________________

Address:____

City:__________________________________ _______State____ __Zip__________

Recipient: Information released to:

Name:____Phone________________________

Address:____

City:____ State____ Zip__________

Medical record information to be released: start date________________end date__________________

- ❑ Office visit/telephone notes
- ❑ Mammogram Results
- ❑ Pap Results
- ❑ Lab/test results
- ❑ Hospital reports
- ❑ Operative Procedure Reports
- ❑ Abstract/pertinent information
- ❑ Prenatal Records
- ❑ Ultrasound
- ❑ DEXA(Bone Density)
- ❑ Other______________________

The following information will be released when included in the above information unless you indicate otherwise.

- Treatment for Alcohol and/ or Drug Abuse (Substance abuse)
- Psychiatric or mental care/treatment
- HIV related information (Aids related testing)
- Sexually Transmitted Disease related- information and testing

Reason for release:

- ❑ Consult/second opinion, personal
- ❑ Legal
- ❑ Insurance underwriting
- ❑ Out of town move
- ❑ Selected new physician
- ❑ Referred by Dr/continuing care
- ❑ School
- ❑ Other______________________

- ➢ I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- ➢ I understand when my information is used or disclosed pursuant to this authorization it may be subject to redisclosure by the recipient and may no longer be protected by Federal HIPAA privacy rule.
- ➢ I understand that I may revoke this authorization at any time (provided such revocation is in writing to the providing organization's privacy official) except to the extent that the practice has acted in reliance upon this authorization.
- ➢ The consent will automatically expire on the following date, event__________ or if not indicated in one year.
- ➢ I have a right to receive a copy of this form after I sign it.

I authorize the above provider to release the information marked above to the recipient.

Signed by: ________________________________ ____________________
Signature of patient Date

____
Patient's Name(print)

________________________________ ____________________
Signature of legal guardian Date

____
Legal Guardian name(print)