PARK PLACE
SURGICAL HOSPITAL
PHYSICIAN OWNED—PATIENT FOCUSED

Authorization for Use and/or Disclosure of Protected Health Information

Patient's Name: _____ **Date of Birth:** _____

Mailing Address: _____

City, State & Zip: _____ **S.S#:** _____

Information to be released:
Date of Service: _____

____ History & Physical	____ Laboratory Reports	____ Doctors' Order
____ Operative Report	____ EKG Reports	____ Progress Notes
____ Procedure Notes	____ X-ray Reports	____ Nurses' Notes
____ Discharge Summary	____ Pathology Reports	____ All Records
____ Other (Please Specify)		

_____

_____

Date of Disclosure: _____

Purpose of Disclosure: _____

____ (initials) I acknowledge and herby consent to the release of protected health information that may contain alcohol, drug abuse, psychiatric.
____ (initials) I acknowledge and herby consent to the release of protected health information that may contain HIV testing, HIV results, or AIDS information.

- I understand that the information which I authorize to be releases may be re-disclosed and no longer protected by state and federal privacy regulations.
- I understand that this authorization is voluntary and that I may refuse to sign.
- I understand that Louisiana Law and regulations allow for fees/charges to be applied to this release of information.
- I understand that I may inspect or copy the information used or disclosed upon request.
- I understand that I may revoke this authorization at any time by notifying Park Place Surgical Hospital in writing, except to the extent that:
    - Action has been taken in reliance upon this authorization; and,
    - If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy itself.
- I understand that I have a right to request and receive a Notice of Privacy practices from Park Place Surgical Hospital.
- I understand that I may receive a copy of this authorization upon request.

Information to be released to:
Name: _____

Address: _____

Phone#:_____

Information is to be:
☐ **Mailed** ☐ **Pick up in person** ☐ **Faxed to:** _____ ☐ **Emailed** _____

This authorization will expire on (Date) _____

Hospital Use Only
Requested information: ☐ Mailed ☐ Faxed ☐ Emailed Date/Time: _____
Hospital Representative Signature: _____

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***If no date is provided, the authorization will expire one year from the date the authorization was signed.**

***Proof of identity via photo identification is required before any requested information will be released.**

I authorize and request the following information from the medical record of my treatment from the above facility. I release Park Place Surgical Hospital from all legal liability that may arise from the release of the information requested. This consent may be revoked at any time, but not retroactive to the release of information already made in reliance upon previously provided authorization.

_____ _____

Signature of Patient Date Signature of Witness Date

_____ _____

Signature of Legal Guardian if under the age 18 Relationship to Patient

Authorization can be revoked in writing by providing written request for revocation to:
Park Place Surgical Hospital
4811 Ambassador Caffery Pkwy Suite 100
Lafayette, LA 70508

Hospital Use Only

Requested information: ☐ Mailed ☐ Faxed ☐ Emailed Date/Time: _____

Hospital Representative Signature: _____