

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

<p><b>Tulane University</b> <b>Medical Group</b></p>	<p>1430 Tulane Ave. – TW22 New Orleans, LA 70112</p> <p>Clinic Tel. No. _____</p>	<p><b>Authorization/Release of Medical Information</b></p>		
<p>This authorizes _____ (Organization) (Individual Releasing information)</p> <p>_____ (Address)</p> <p>to release the following information on _____ (Patient's Name) (DOB) (Medical Record Number)</p> <p>to _____ (Organization) (Individual Receiving Information)</p> <p>_____ (Mailing Address)</p>				
<p>for the purpose of</p> <table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none;"> <input type="checkbox"/> Insurance claim  <input type="checkbox"/> Continued care by another physician or health care facility  <input type="checkbox"/> Disability determination  <input type="checkbox"/> Marketing                 </td> <td style="width:50%; border:none;"> <input type="checkbox"/> Research  <input type="checkbox"/> Publicity related activities  <input type="checkbox"/> Fundraising  <input type="checkbox"/> At the request of individual  <input type="checkbox"/> Other (please state reason for release) _____                 </td> </tr> </table> <p>This authorization will expire on _____</p>			<input type="checkbox"/> Insurance claim <input type="checkbox"/> Continued care by another physician or health care facility <input type="checkbox"/> Disability determination <input type="checkbox"/> Marketing	<input type="checkbox"/> Research <input type="checkbox"/> Publicity related activities <input type="checkbox"/> Fundraising <input type="checkbox"/> At the request of individual <input type="checkbox"/> Other (please state reason for release) _____
<input type="checkbox"/> Insurance claim <input type="checkbox"/> Continued care by another physician or health care facility <input type="checkbox"/> Disability determination <input type="checkbox"/> Marketing	<input type="checkbox"/> Research <input type="checkbox"/> Publicity related activities <input type="checkbox"/> Fundraising <input type="checkbox"/> At the request of individual <input type="checkbox"/> Other (please state reason for release) _____			
<p><b>DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED</b></p>				
<p>Is this request for psychotherapy notes?</p> <p><input type="checkbox"/> Yes. Then this is the only item you may request on this authorization. You must submit another authorization for other items below.</p> <p><input type="checkbox"/> No. Then you may check as many items below as needed.</p> <p style="padding-left: 40px;"> <input type="checkbox"/> Medical Record                      <input type="checkbox"/> Itemized bill                      <input type="checkbox"/> Other _____             </p> <p>Specific description of information to be used or disclosed _____</p> <p>_____</p>				
<p>I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, and/or genetic test results. _____ (Initial)</p> <p>I hereby consent to release my HIV test results: _____ (Initial) I have a right to refuse to release my HIV test results, except where release is authorized by law without my consent.</p>				
<p>I understand that :</p> <ol style="list-style-type: none"> <li>1. I may refuse to sign this authorization and that it is strictly voluntary.</li> <li>2. If I do not sign this form, my health care and the payment for my health care will not be affected.</li> <li>3. I may revoke this authorization at any time in writing, but if I do, it will not have an effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.</li> <li>4. If the receiver is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations and may be re-disclosed.</li> <li>5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.</li> <li>6. I may have a copy of this form after I sign it.</li> </ol>				
<p><b>SIGNATURES</b></p>				
<p>I have read the above and authorize the disclosure of the protected health information as stated.</p>				
<p>Signature of Patient/Guardian/Patient Representative:</p>	<p>Date:</p>			
<p>Print Name of Patient's Representative:</p>	<p>Relationship to Patient:</p>			