Authorization to Release or Obtain Health Information

Please return this Authorization to Release or Obtain Protected Health Information via mail or fax to:

LHC Group, Inc. – Privacy Office
901 Hugh Wallis Road South
Lafayette, LA 70508
Fax Number: 1-866-632-9050

Patient Name:	Date of Birth:	Last 4 Digits of SSN:

I authorize:

Name:_____

Mailing Address: _____

Telephone Number: _____ Fax Number:_____

☐ **TO RELEASE Information TO** **OR** ☐ **TO OBTAIN Information FROM**

Name:_____

Mailing Address: _____

Telephone Number: _____ Fax Number:_____

Method of Delivery:

☐ Fax ☐ Mail ☐ Hand Delivery ☐ Pick Up ☐ Secure Email (if selected, list email address):

The purpose of this authorization is indicated in the box(es) below. ***(Place an "X" in the box(es) that apply.)***

☐ Further Medical Care ☐ Personal ☐ Legal ☐ Changing Physicians ☐ Disability ☐ Insurance ☐ Other: _____

I authorize the release of the following protected health information for the dates of service(s) listed: _____

(Place an "X" in the box(es) that apply to information you want released or to obtain.)

☐ Entire Medical Record ☐ History and Physical ☐ Plan of Care ☐ Oasis ☐ Treatment or Tests ☐ MARS/Medications ☐ Physician Orders
☐ Therapy Notes ☐ Laboratory Reports ☐ Nursing Notes ☐ Discharge Summary ☐ Other: _____

For Social Worker purposes:

☐ Electric Company ☐ Area on Aging ☐ Meals on Wheels ☐ Homemaker Services ☐ Other _____
Name of Resource Company: _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here ☐

If this authorization is for disclosure of genetic information, please explain: _____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If this authorization is for genetic information, it is invalid if used for any purpose other than that specified above.
5. If the requester or 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.
6. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.

This authorization shall expire on _____ (date or event)

I understand that if I do not specify an expiration date, this authorization will expire one (1) year from the date on which it was signed. I acknowledge that I have read this form. If this authorization is for disclosure of genetic information, it will expire 60 days from the date it is signed.

_____ _____
Signature of Patient/Patient's Representative Date

_____ _____
Print Name of Patient/Patient's Representative Relationship to Patient

Proof of identification should accompany this patient authorization form (See examples below):
- Copy of License - Social Security Card - Power of Attorney - Admission Documentation to Verify Signature - Death Certificate