ARK-LA-TEX FERTILITY AND REPRODUCTIVE MEDICINE

2401 GREENWOOD RD, SHREVPORT, LA 71103
PHONE 318-841-5800 FAX 318-841-5817

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

_____ _____
Printed Patient Name Previous Names, if applicable

_____ _____
Date of Birth Daytime Telephone Number

SEND INFORMATION TO: (please be specific)

Provider Name/Organization: _____
Address: _____
_____
Phone #_____ Fax#_____

INFORMATION TO BE RELEASED FROM: (please be specific)

Provider Name/Organization: _____
Address: _____
_____
Phone #_____ Fax#_____

PURPOSE OF DISCLOSURE: Transfer of Care, Self, Specialist, Other_____ (must complete)

INFORMATION TO BE DISCLOSED:

Medical Records from last two years_____
Summary Health Information_____ Dates of Service: _____
Complete Designated Record Set_____
Other_____

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by HIPAA of 1996. I acknowledge that I have received a copy of the Notice of Privacy Practices_____
Initials

_____ _____ _____
Date **Signature of Patient or Representative** **Relationship to Patient**

DISCLOSURES REQUIRING SPECIAL CONSENT:
My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

HIV/AIDS Virus_____ Mental health/Psychiatric Disorders_____
Sexually Transmitted Diseases_____ Drug, Alcohol abuse/treatment_____

_____ _____ _____
Date Signature of Patient or Representative Relationship to Patient

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For Facility Use:
Date Received: _____ Date Information Released: _____
Person/Department Sending Records: _____

ARKLATEX FERTILITY