MOREHOUSE COMMUNITY MEDICAL CENTERS, INC.

518/520 Durham Street
Bastrop, La 71220
Phone 318-283-8887 Fax 318-281-6339

RELEASE OF PATIENT INFORMATION AUTHORIZATION FORM

☒ Release a copy of Medical Records to:

NAME: _____
ADDRESS: _____
_____
RELATIONSHIP TO PATIENT: _____
PHONE: _____
REASON FOR RELEASE: _____
(Not required if disclosure is requested by patient)

I hereby authorize Morehouse Community Medical Centers, Inc. to disclose to the above named individual(s)/organization(s) the following requested health information:

INFORMATION TO BE DISCLOSED:

___ Complete Health Record(s)
___ Lab Reports
___ Consultation Report
___ History & Physical
___ Discharge Summary
___ X-ray Reports
___ Progress Notes
___ Operative Report
___ EKG, EEG
___ Other _____

Authorization expiration date or event expiration: _____

I understand the following information will be released when included in the above unless I indicate otherwise:

☐ Do not release any AIDS or HIV test results
☐ Do not release any records of behavioral health services/psychiatric care
☐ Do not release any records of treatment for alcohol and/or drug abuse

I **understand** that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Morehouse Community Medical Centers, Inc. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
I **understand**, unless otherwise revoked, this authorization will be in effect for the dates indicated above, or will automatically expire twelve (12) months form the date of the authorization.
I **understand** that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws.
I **understand** authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.
I **understand** Morehouse Community Medical Centers, Inc, its affiliated entities, its employees, officers, and physicians are hereby release from my legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

IDENTIFYING INFORMATION:

Patient's name at the time of treatment: _____

Date of Birth: _____ SS #: _____

Signature of Patient or Legal Representative: _____

Date: _____ If signed by legal Representative, relationship: _____

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non applicable or specifically not authorized for release. This authorization is not valid if it does not contain the patient's original signature and date signed or if it has expired.

Distribution of copies: Original to patient medical record, copy to patient, copy to accompany use or disclosure