UNION GENERAL HOSPITAL

901 James Ave., Farmerville, La. 71241
Phone: (318) 368-9751 Fax: (318) 368-7093

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name	**Date of Birth**
Social Security Number	
Address	

***Provider authorized to release the Health Information (the "Provider"):**	(Name of releasing entity)
***Entity to receive the Health Information (the "Recipient"):**	(Name of receiving entity)
Recipient's Address:	Address
	Attention:

***Dates of service of the Health Information that is covered by this authorization:**			
	Start date:	End date:	
	Start date:	End date:	
***Health Information related to the patient to be released under this authorization:**			
	Complete health record		
	Discharge Summary		Progress Notes
	History &Physical examination		Laboratory tests
	Consultation reports		X-ray report
	Other (Please specify)		
The following information will be released when included in the above unless you indicate otherwise:			
	Do not release any AIDS or HIV test results		Do not release any records of psychiatric care
	Do not release any records of alcohol/substance abuse treatment		
	Other:		
	If checked, this authorization allows the Provider to use or disclose your information for marketing purposes and the Provider receives direct or indirect remuneration from a third party for that marketing use or disclosure.		
	If checked, this is a conditional authorization, and you will not receive the following services unless you sign this authorization (describe any consequences of refusing to sign):		

***Purpose of disclosure**

Not to be used for release of genetic test.

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*Authorization expiration date or event:

*Patient's signature	Date
*Personal representative's signature (if necessary)	Date
Note: If signed by a "personal representative" of the patient, please complete the Personal Representative section.	

*Personal Representative	
If it is necessary for a personal representative to sign and date this authorization due to lack of capacity of the patient, including minority, interdiction or any other legal reason, indicate below how the person signing as personal representative has authority to do so:	
	(1) The judicially appointed tutor or curator of the patient, if one has been appointed.
	(2) An agent acting pursuant to a valid mandate, specifically authorizing the agent to make health care decisions.
	(3) The patient's spouse not judicially separated.
	(4) An adult child of the patient.
	(5) Any parent, whether adult or minor, for his minor child.
	(6) The patient's sibling.
	(7) The patient's other ascendants or descendants.
	(8) Any person temporarily standing in loco parentis, whether formally serving or not, for the minor under his care and any guardian for his ward.
	(9) Other (Please specify):

The undersigned patient (or personal representative on behalf of the patient) hereby authorizes the Provider named above to release the Health Information described above to the Recipient named above. The patient has the right to refuse to sign this authorization.

The Provider cannot condition treatment, payment, enrollment, or eligibility for benefits on the patient providing this signed authorization, except in very limited circumstances. If this is one of those circumstances, the consequences of refusing to sign are described on the front.

This authorization to release the health information listed above can be revoked at any time (upon written notification to the Recipient at the above address) except to the extent that (1) Provider has already released the Health Information before being notified of the revocation, or (2) Provider has taken action in reliance on this authorization. Provider's Notice of Privacy Protections contains more information on how to revoke this authorization. This authorization will expire on the expiration date or event date listed above.

When the Patient's health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the Recipient or any of its agents and/or employees and may no longer be protected by 45 CFR Parts 160 and 164.

A photocopy of this authorization may serve as an original.

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