BATON ROUGE ORTHOPAEDIC CLINIC
8080 Bluebonnet Blvd., Suite 1000
Baton Rouge, LA 70810

Request for Access To and Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Name:_____ Date of Birth:_____

Street Address:_____ Tel # (cell):_____

City, State ZIP:_____ Tel # (home):_____

Email Address:_____ Tel # (work):_____

I request my records to be delivered by: ☐ Electronic Delivery ☐ Mail (paper) ☐ Picked Up (paper) ☐ Fax to Physician

**Films cannot be provided electronically and are available on a disc and for mail or pick-up only*

I hereby authorize Baton Rouge Orthopaedic Clinic to Disclose my Protected Health Information to:

Facility/Individual Name:_____ Relationship:_____

Attention:_____ Fax #: _____

Street Address:_____ Tel #: _____

City, State ZIP:_____ Email Address:_____

Information Be Released for TREATMENT DATES: From (date): _____ **To (date):** _____

TYPE OF INFORMATION TO BE RELEASED:

- ☐ Office Notes Only
- ☐ Physical Therapy Notes
- ☐ Itemized Billing Statement
- ☐ Other:_____
- ☐ Other:_____
- ☐ Radiology Reports Only
- ☐ Complete Health Record
- ☐ X-ray or MRI (disc only)
- ☐ Other:_____
- ☐ Other:_____

PURPOSE OF THE REQUEST for PHI DISCLOSURE:

- ☐ Treatment/Consultation
- ☐ Personal Request
- ☐ Insurance
- ☐ Legal (specify):_____
- ☐ Other (specify):_____

Drug and / or Alcohol Abuse, and / or Psychiatric, and / or HIV / AIDS Records Release:
I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check one:*** ☐ **Yes** ☐ **No**

Time Limit & Right to Revoke Authorization:
Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Department of Health Information Systems or other Department to whom you are authorization disclosure. Unless revoked, this Authorization will expire on the following date or event_____, or 90 days from the date of signature, unless otherwise specified.

Re-release:
I understand that the information released pursuant to this Authorization may be subject to release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Cost of Records:
Patient requests for records to be delivered to a healthcare provider will be processed at no charge, and the first Patient request for records delivered to the Patient are processed at no charge. All other Patient requests will be processed at $6.50/request for records and $25/disc for x-ray/MRI images (on a disc) + actual delivery charges, and payment due in advance. Please direct all **questions to ResolveROI at 1-844-887-8109** and **requests may be faxed to 225-408-7980 or delivered to the address above**.

Signature of Patient or Personal Representative Who May Request Disclosure
By signing below, you authorize your healthcare provider identified above to release your protected health information, and acknowledge and understand the terms of this **Request for Access to and Authorization for Use and Disclosure of Protected Health Information**.

Patient / Personal Representative signature: _____ Date: _____

Relationship to Patient: _____