AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize **IBERIA MEDICAL CENTER** to release or disclose the health records of:

Patient Name:	**MR#:**
Date of Birth:	**SS#:**

The information is to be released TO: _____
(RECIPIENT of medical information)

For the PURPOSE of:

___ Further care / treatment ___ Access / Review ___Other:_____
___ Personal - at my request

For the PERIOD(s): _____

Specify the records to be released for the period(s) specified:

___COMPLETE RECORD(S)	___Consultation	___Lab	___Radiology Report
___Abstract summary	___Progress Notes	___Pathology	___Radiology Images / CD
___Discharge summary	___ER abstract	___Cardiopulmonary	___Bills
___History & Physical	___ER complete record	(specify: EKG, EEG, Stress Test)	
___Operative Report	___Other, specify:_____		

If initialed below, I also specifically authorize release of the following:

___ Mental health records and records indicating psychological or psychiatric impairment(s)
___ Drug abuse or alcoholism treatment records
___ Sickle cell anemia
___ Tests for Acquired Immunodeficiency Syndrome (AIDS)
___ Tests for infection with human immunodeficiency virus (HIV)
___ Other (specify):_____

Specify format the records are to be released: (Check one and give phone number, address,)

___ Hard copy
___ Electronic _____
___ Other _____ _____

IMPORTANT NOTICE: Electronic copies are provided on hospital-approved storage media.

IMPORTANT WARNING REGARDING EMAIL: There is a level of risk that any information transmitted in an email or via fax could be read by a third party. Should you still wish to receive the requested information via email, we are not responsible for unauthorized access to your information during transmission.

This authorization will expire in 12 months unless an earlier date, event, or condition is specified here:

NOTE: The patient or representative may revoke this authorization in writing to the same medical records custodian receiving this authorization form, but such revocation may not be retroactive to the release of information made in good faith. Information disclosed pursuant to this authorization is subject to re-disclosure by the recipient. Iberia Medical Center and its healthcare delivery sites do not condition treatment on the whether or not this authorization is signed. <Refer to our current *"Notice of Privacy Practices"* for an explanation of ways your medical information may be used without a signed authorization.>

PATIENT OR LEGAL REPRESENTATIVE (Parent must sign if patient under age 17)	**RELATIONSHIP TO PATIENT**	**DATE**

WITNESS (to signature only)	**DATE**