Primary Care Plus
Handling your health with care

Authorization for the Release of Protected Health Information (PHI)

Patient Name (Last, First, Middle): _____ Date of Birth: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip code: _____

Contact Phone Number(s): _____

I hereby authorize the following entity to release the Protected Health Information (PHI) below to:
Primary Care Plus, 2633 Napoleon Ave, Suite 400, New Orleans, LA 70115
Telephone: (504)897-3305 Fax: (504)897-3331

Entity Possessing the PHI: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number(s): _____ Fax: _____

If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated

PHI and Dates of PHI Authorized for Use of Disclosure

Description	Start & End Date of PHI	Description	Start & End Date of PHI
[ ] All PHI Records	_____	[ ] History & Physical Exam	_____
[ ] Laboratory Test	_____	[ ] X-Ray Tests/Reports	_____
[ ] Progress Notes	_____	[ ] Discharge Summary	_____
[ ] Consultation Reports	_____	[ ] Itemized Billing Statement	_____

[ ] Other _____

****The following information will be released unless you indicate DO NOT RELEASE by checking the appropriate box**

[ ] AIDS/HIV OR STD treatment [ ] Psychiatric/Mental Care [ ] Alcohol/Drug/Substance Abuse [ ] Genetic Screening

Other, please specify: _____

I understand that:

- I may refuse to sign this authorization and it is strictly voluntary.
- My treatment, payment, enrollment of eligibility of benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing to the provider authorized to release the PHI, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed.
- I have the right to receive a COPY of this form after I sign it.
- I will receive a photocopy only of my medical record and that the original will remain with Primary Care Plus

Signature of Patient or Patient's Representative (if applicable): _____ Date: _____

Personal Representative's Relationship to Patient and Description of Authority to Act: _____