NOLA OB GYN
Women's Health Clinic

9954 Lake Forest Blvd Suite #10

New Orleans, LA 70127

Phone: (504)-273-1075 Fax: (504)-293-7244

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

THIS AUTHORIZATION EXPIRES THIRTY DAYS AFTER IT IS SIGNED.

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize_____

to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

MY RIGHTS

- I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility). However, I do have to sign an authorization form to receive health care when the purpose is to create health information for a third party or to take part in a research study.
- I may revoke this authorization in writing by sending a letter to the health care provider to whom the authorization is directed. If I did it would not affect any actions already taken by the health care provider based upon this authorization.
- I may not be able to revoke this authorization if its purpose was to obtain insurance.
- I understand that once the health care provider discloses my health information, the person or entity that receives it may re-disclose it. The HIPAA Privacy laws may no longer protect it.
- I also realize that I am responsible for fees incurred by the copying of my medical record. Our current fees are as follows: .36 cents for each page up to 200 pages then the fee reduces to .12 cents for each additional page. (Maximum fee of $400.00) I understand that I will be provided with a concise charge for these services and that these fees will need to be paid before my medical records are released.
- North Oaks Obstetrics & Gynecology, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to extent indicated and authorized herein.

Patient Signature: _____ Date Signed: _____