LOUISIANA EYE&LASER CENTER

The TOTAL EYE CARE TEAM

A.J. Barbiero, O.D.
Bernard E. Patty, III, M.D.
Brett Bennett, O.D.
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Richard M. Walters, O.D.
Silva Hamade, O.D.
T. Chadwick Norton, M.D.

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

| | | |
|---|---|---|
| **PURPOSE OF THIS DISCLOSURE:** | | **PHONE** |
| **PATIENT NAME (Last, First, Middle)** | | **DOB** |
| **ADDRESS** | | **SSN** |
| **CITY** | **STATE** | **ZIP** |

| **PROVIDER AUTHORIZED TO RELEASE THE PHI:** | **ENTITY RECEIVING THE PHI:** | | |
|---|---|---|---|
| | **NAME** | | |
| | **ADDRESS** | | |
| | **CITY** | **STATE** | **ZIP** |
| | **ATTENTION:** | | |
| **This authorization will expire on the following date or event** | **DATE** | **EVENT** | |

**PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE**

| Description | Start Date | End Date |
|---|---|---|
| ❑ All PHI in the record | | |
| ❑ Progress Notes | | |
| ❑ Laboratory Tests | | |
| ❑ X-Ray Tests/Reports | | |
| ❑ History and Physical Examination | | |
| ❑ Consultation Reports | | |
| ❑ Itemized Billing Statement | | |
| ❑ Other: | | |

**I UNDERSTAND THAT:**

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment,enrollment or eligibility benefits may not be a conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the PHI, but I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requester 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.
5. I have the right to receive a copy of this form after I sign it.

| | |
|---|---|
| **Signature of Patient:** | **Date** |
| **Signature of Patient's Representative (if necessary)** | **Date** |
| **Personal Representative's Relationship to Patient** | |