

Cardiac and Vascular Services of Cenla  
1587 N. Bolton Ave., Suite 1400  
Alexandria, LA 71303-4255

A. Craig Pearce, M.D. and Kanna V. Posina, M.D.

Phone # (318) 443-8090

Fax # (318) 767-3803

## HIPAA RELEASE OF MEDICAL RECORDS

Authorization for Use or Disclosure of Protected Health Information  
(Required by the Health Insurance Portability and Accountability Act- 45 CFR Parts 160 and 164)

1. I, \_\_\_\_\_ whose date of birth is \_\_\_\_\_ hereby authorize \_\_\_\_\_ and its affiliates, its employees and agents, to release to **Cardiac and Vascular Services of Cenla.**
2. Authorization for Release of Information. Covering the period of health care from:  
\_\_\_\_\_ to \_\_\_\_\_ OR \_\_\_\_\_ all past, present and future periods:
  - a. \_\_\_ I hereby **authorize the release of my complete health record** (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse)
  - b. \_\_\_ I hereby **authorize the release of my complete health record with the exception of the following information:**
    - \_\_\_ Mental health records
    - \_\_\_ Communicable diseases (including HIV and AIDS)
    - \_\_\_ Alcohol/drug abuse treatment
    - \_\_\_ Other (please specify): \_\_\_\_\_
3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
4. This authorization shall be in force and effect until \_\_\_\_\_, at which time this authorization expires.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Personal Representative Relationship to Patient