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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 **Central Louisiana Foot and Ankle Specialists.**
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