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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 **Cenla Family Medicine Associates, LLC.**

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