HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)			DOB
ADDRESS		SSN	
CITY	STATE	ZIP	PHONE

PROVIDER AUTHORIZED TO RELEASE THE PHI:	SEND COPIES OF MY RECORD TO MY NEW PROVIDER:		
MEDSOUTH RECORD MANAGEMENT, LLC ON BEHALF OF LOUISIANA HEART MEDICAL GROUP ALL LOCATIONS	NAME		
	ADDRESS		
	CITY	STATE	ZIP
	EMAIL/FAX:		

This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire 12 months from date signed.

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
❑ Abstract of the record		
❑ Progress Notes		
❑ Laboratory Tests		
❑ X-Ray Tests / Reports		
❑ History and Physical Examination		
❑ Discharge Summary		
❑ Consultation Reports		
❑ Itemized Billing Statement		
❑ Other:		

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results
[ ] Alcohol, drug or substance abuse treatment
[ ] Psychiatric or mental care / treatment
[ ] Other (specify):

I UNDERSTAND THAT:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY.
2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF 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 REDISCLOSED.
5. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.
6. **PURPOSE: TRANSFER OF CARE TO A DIFFERENT PROVIDER OR FOR PERSONAL USE - DUE TO THE CLOSURE OF LOUISIANA HEART MEDICAL GROUP, I AM REQUESTING MY RECORDS BE RELEASED.**

Signature of Patient:	**Date:**
Signature of Patient's Representative (if necessary):	**Date:**

Personal Representative's Relationship to Patient:

$25 fee must accompany your request, checks should be made out to and this form should be returned to:

MedSouth Record Management, LLC
P. O. Box 1630
Mandeville, LA 70460
FAX: 985-951-7101 or Email: lhmg@medsouthrecord.com