THIBODAUX REGIONAL MEDICAL CENTER
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT NAME_____ **DATE OF BIRTH**_____

This is to authorize_____ to release
Name of Hospital/Physician
to_____
Name of Hospital, Physician, or Third Party
_____
Complete Mailing Address

Telephone Number_____ Fax Number_____

Type of record requested: ☐ **Inpatient** ☐**ODS** ☐ **Outpatient** ☐**ER**
☐ Facesheet ☐ Consultation ☐ History and Physical Report
☐ Operative Report ☐ Physician Progress Notes ☐ Discharge Summary
☐ Lab/X-Ray Reports ☐ Complete Hospital Record ☐ Problem List
☐ Other_____

Covering the period of hospitalization/treatment from_____to_____.
- ☐ I will review records at Thibodaux Regional Medical Center.
- ☐ I wish to have my records copied and I will pick them up at the facility.
- ☐ I am requesting that the facility copy my medical records and mail the records to the above address.

I understand that the information indicated above is considered confidential and is to be utilized by the recipient only for the following purpose:
☐ Continued Treatment ☐ Processing/Application of Insurance/Benefits
☐ Employment ☐ Legal ☐ Other_____
Specify other limited purpose

I understand that the medical record may contain information relating to psychological/psychiatric conditions, alcohol or drug abuse, AIDS testing or testing for the HIV antibody or antigen and/or genetic testing. I understand that I have the right to refuse to disclose psychological/psychiatric conditions, alcohol or drug abuse, HIV test results and/or genetic testing. I specifically authorize release of the following types of information:
☐ Psychological/psychiatric conditions ☐ Alcohol or drug abuse
☐ AIDS testing or testing for the HIV antibody or antigen ☐ Genetic testing
I further understand that I am not giving permission for any re-disclosure other than the specified above. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected. I hereby waive and release the above named hospital, physician(s), and any member of their staff from any restriction or privilege imposed by law in disclosing or revealing any professional record, observation, or communication.

This authorization is subject to revocation at any time except to the extent that the releasing party has already taken action on it. The revocation must be in writing and delivered to the Health Information Management Department. If not previously revoked, this authorization will terminate 90 days from the date of my signature.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain further treatment from Thibodaux Regional Medical Center, nor will it affect my eligibility for benefits.

I do hereby expressly and voluntarily consent to disclosure of the medical record information for the purpose or need as stated above.

_____ _____
Signature of patient or authorized legal representative Date

_____
Relationship

Verbal consents require (2) witnesses' signatures indicating consent but unable to provide signature.

_____ _____
Signature of witness/relationship to patient or credentials Date

_____ _____
Signature of witness/relationship to patient or credentials Date