AFFINITY HEALTH GROUP

Improving Lives, Improving Care

130 DeSiard Street Ste 355 Monroe, LA. 71201
Phone: (318) 807-7875 Fax: (318) 807-1620

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please complete the following information: (please print**)**

Patient Name: _____ DOB: __/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Check all applicable:

_____	Complete Medical Record	_____	Billing Records
_____	Lab/Pathology Records	_____	Immunization Records
_____	X-ray/Radiology Records		
_____	Other (describe specifically):	_____	

I authorize Affinity Health Group:
☐ to release my medical records to: ☐ to obtain records from:

_____

_____

_____

Initial if applicable:

_____ I specify that this authorization extends to cover release of information related to HIV/AIDS.

_____ I specify that this authorization extends to cover release of information related to Genetic testing.

_____ I specify that this authorization extends to cover release of information related to Psychiatric/Mental Health and/or Drug and Alcohol abuse treatment information.

This information about you is protected under federal and state law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal and state law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

Signature of patient (or patient's representative)	Date
Printed name of patient (or patient's representative)	Representative's authority to sign for patient (i.e. parent, guardian, power of attorney)

Internal Use Only: Revised 2017/07/20

Records given via ☐CD ☐Paper ☐USB ☐Other _____