CrescentCare
A Partnership for Life

AUTHORIZATION FOR RELEASE OF CRESCENTCARE MEDICAL INFORMATION

Patient Information:

Full Name: _____ **Date of Birth:** _____

Phone Number: _____ **Email:** _____

Street Address: _____

City, State, Zip: _____

Recipient of Information: I authorize the release of my CrescentCare protected health information (PHI) **TO**:

____ **Myself via (check one):** ____ Patient portal ____ Encrypted Email ____ Pick Up

Or to:

Name/Organization: _____

Street Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____ **Email:** _____

Information to Be Disclosed (Check all that apply):

☐ Complete Medical Record
☐ Immunization Records
☐ Lab/Pathology Results
☐ Visit Notes
☐ Dental Record
☐ Diagnostic Reports
☐ Other (Specify): _____

The following requires specific patient authorization under Louisiana and/ or Federal law. Please initial to release:

_____Behavioral Health Records _____Substance Use Disorder Records _____HIV/AIDS Testing & Treatment

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Purpose of Disclosure:

☐ Continuity of Care
_____ I am no longer a CrescentCare patient/client
☐ Insurance
☐ Legal
☐ Personal Use
☐ School/Work
☐ Other: _____

Expiration of Authorization: This authorization will expire in 1 year unless otherwise indicated below:

Date (not to exceed 12 months) or event: _____

Patient Rights and Acknowledgments:

- I understand that I may revoke this authorization in writing at any time by submitting a signed letter to CrescentCare, except to the extent that disclosure has already occurred.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my signing this authorization.
- I understand that once my information is released, it may be redisclosed by the recipient and may no longer be protected by HIPAA.
- I understand that if this authorization includes sensitive information (e.g., mental health, HIV/AIDS, drug/alcohol use), it will only be released if specifically authorized above.

Patient Signature: _____ **Date:** _____

If signed by someone other than the patient, indicate authority: ☐ Parent of minor ☐ Legal Guardian ☐ Power of Attorney ☐ Other: _____

Name: _____ **Relationship to Patient:** _____

Phone Number: _____ **Email:** _____

Signature: _____ **Date:** _____