Consent to Release Information

Foster-Johnson Health Center

ALL SECTIONS ARE REQUIRED. MUST PROVIDE PHOTO ID PRIOR TO RELEASE OF INFORMATION.

1. I AUTHORIZE THE FOLLOWING PROTECTED HEALTH INFORMATION TO BE RELEASED FROM THE HEALTH RECORD OF:

Last Name	First name	Date of Birth (MM/DD/YYYY)

Phone Number	G Number	Last 4 digits of Social Security No.

Street Address	City	State	Zip Code

2. RELEASE RECORDS ◯ **FROM** **or** ◯ **TO** ↔ ◯ **FROM** **or** ◯ **TO**

Foster-Johnson Health Center
Grambling State University
403 Main St., Box 4251
Grambling, LA 71245
Phone: (318) 274-2351 Fax: (318) 274-2481

Name/Agency _____
Street Address _____
City/State/Zip Code _____
Phone _____ Fax _____

◯ **Fax Records** ◯ **Mail Records** ◯ **Pick Up**

Medical records (other than immunization/skin test results) can be faxed to medical facilities only

3. INFORMATION TO BE RELEASED/OBTAINED

HEATLH INFORMATION	CONTENT
◯ Physician/Nurses Note(s)	_____
◯ Depo-Provera Records	_____
◯ Immunization Records	_____
◯ Laboratory Results	_____
◯ X-Ray Reports	_____
◯ Other	_____

4. PURPOSE OF THE REQUESTED DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____

5. DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE/OBTAIN

I understand if my medical or billing record contains information in reference to drug and or alcohol abuse and/or psychiatric care, sexually transmitted disease/infections, hepatitis B or C testing, and/or other sensitive information, I agree to its release.

◯ Yes ◯ No Sign here to release/obtain _____

I understand if my medical or billing record contains information in reference to HIV/AIDs testing and/or treatment, I agree to its release.

◯ Yes ◯ No Sign here to release/obtain _____

6. EXPIRATION DATE

Unless revoked, this authorization will expire 30 days from the date of signature unless specified here _____.
MM/DD/YYYY

RIGHT TO REVOKE AUTHORIZATON

I understand that my permission to release this information may be revoked at any time by submitting a written notice to Foster-Johnson Health Center except when the information has already been released.

RE-DISCLOSURE

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

7. I understand and authorize this release. _____ _____ **Print**
Signature Date

Revised: November 2014