FIRE PROTECTION DISTRICT NUMBER FOUR ST. TAMMANY PARISH LOUISIANA,
HEALTH CARE COMPONENT - CHAPTER 16 - Patient Release Authorization

Last name: _____ First: _____ Middle: _____
Other Names Used: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____

I hereby request access to the protected health information in my health record from (date) _____ to (date) _____ maintained or created by the provider named below to the recipient named below.

☐ Most recent Progress Notes
☐ Pathology/Lab Reports
☐ X-ray Reports/Films
☐ Discharge Summaries
☐ Billing Records
☐ Immunization Records

☐ Entire Health Record *(*Excludes Psychotherapy Notes*)
☐ Other _____
☐ Psychotherapy Notes* (*if checking this box, no other boxes may be checked. A separate Authorization to Release/Request for an Individual's Health Information must be completed to obtain additional records*)

☐ I will pick up copies of my records ☐ Mail copies of my records to the individual/s indicated below ☐ Fax my records to _____
☐ Provide my records in electronic form: _____

Records To	
Name:	
Address:	
Phone:	
Fax:	

Purpose of Request: ☐ patient's request, ☐ dispute, ☐ referral, ☐ other: _____

I understand:

- I may revoke this Authorization at any time by providing my written revocation to Fire Protection District Number Four, Health Care Component, 701 Girod St., Mandeville, LA 70448, Attn: Privacy Officer. My revocation does not apply to information already retained, used or disclosed in response to this Authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be twelve (12) months from the date of signature.

- Unless the purpose of this Authorization is to determine payment of a claim or benefits, Fire Protection District Four, Health Care Component, may not condition the provision of treatment or payment form my care on my signing this Authorization.

- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.**

- *The information authorized for release may include protected health information and/or records related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.

- The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute and alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.

- I understand that if my records are released, I will be charged a reasonable cost-based fee not to exceed $1.00 per page for the first twenty-five (25) pages, $0.50 per pay for twenty-six to three hundred fifty pages (350) and $0.25 per pay thereafter and a handling charge not to exceed $25.00 and actual postage. If the treatment records are generated, maintained or stored in digital format, copies may be requested to be provided in digital format and charged a reasonable cost-based fee not to exceed rates provided above; however, the rate for providing digital copies shall not exceed $100.00 including all postage and handling charges actually incurred.

Signature: _____ Date: _____
(Patient or Personal Representative)

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE:

Type of authority (e.g., court appointed, custodial parent): _____

FILE IN PATIENT RECORD (Retain for a minimum of 6 years)

*Capitalized terms are defined in Definitions
**May be requested to show proof of representative status