Authorization for Release of Protected Health Information by Southeast Neuroscience Center and the Imaging Center of South Louisiana

I, ____(print patient name) hereby authorize Southeast Neuroscience Center and/or the Imaging Center of South Louisiana (collectively, the "Center"), to disclose the protected health information specified below to:

____ Print name of party to receive information

____ Relationship to patient

____ Address of party to receive information

____ Telephone of party to receive information

I authorize the Center to disclose the following health information to the above specified party:

- □ Verbal information only informing the above person(s) about details about my medical information without the production of any written records.
- □ My complete medical records and information including but not limited to, test results, as well as information related to HIV status, drug and alcohol usage, and mental health status (but this Authorization does not include an authorization for the release of psychotherapy notes).
- □ My medical records for the specific treatment dates from _____________ to ___________
- □ The following specific portions of my medical records and health information:____
  ____

1. I authorize Center to use and/or disclose my health information for the following purposes.
   - □ At my request, or
   - □ For the following Purposes*:____

   ____

2. This Authorization expires:□ On the following date:_____________________________________
   ____

   □ When the following event occurs:____

3. I understand that I have the right to revoke this Authorization at any time and that revocation must be delivered in writing to the Center's Members. I am aware that my revocation will not be effective if (i) this Authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself; or (ii) to the extent the Center has already acted in reliance upon this Authorization.

4. I understand that I am under no obligation to sign this form and that the Center may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this Authorization.

5. I understand that if the persons I have authorized by this release to obtain my health information are not health care providers, health plans or health care clearinghouses subject to the federal privacy standards, the health information disclosed pursuant to this Authorization may no longer be protected by the federal privacy standards and such persons may be able to re-disclose my health information without obtaining my authorization.

____
Patient's Signature

____
Date and Time

*If the Authorization is intended to authorize us to disclose records concerning drug or alcohol treatment, federal law requires you to state the purpose of the disclosure.

PATIENT'S LEGAL REPRESENTATIVE MUST PROVIDE PROPER DOCUMENTATION

The above patient is unable to consent because:

□ Minor

□ Incompetent

□ Other (explain): ____

I therefore consent on behalf of the patient named above.

_____________________________ _____________________________
Signature Relationship

____
Date and Time

The individual signing this Authorization is entitled to a copy of this Authorization when it is signed.