



# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

All areas designated by an **▶** are **REQUIRED** for valid authorization.

**1** I authorize

Napoleon Pediatrics  
2820 Napoleon Ave., Suite 950  
New Orleans, LA 70115

▶  to receive from  
 to release to

**2** ▶ Specific Physician, Service Agency or Third Party

**3** ▶ Street Address City State Zip Code

**Information regarding:**

Patient's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Service Dates: \_\_\_\_\_

**4** ▶ I would like the following information from the patient's record mailed to the above:

- Diagnosis, including alcohol and drug abuse
- Billing Information (Paper)
- Lab Reports (Lab)
- History and Physical Report (H&P)
- Results of HIV testing
- Billing Information (Verbal)
- Consultation(s) (Con)
- Other \_\_\_\_\_

I AUTHORIZE the release of HIV test results. I understand I am authorized by law to allow or refuse to allow the release of HIV Test Results. An HIV Test Result is the original document, or copy thereof, transmitted to the medical record from the laboratory or other testing site with the result of an HIV-related test. It does not include any other note, notation, diagnosis, report, or other writing or document.

- I AUTHORIZE the release of HIV test results.
- I DO NOT AUTHORIZE the release of HIV test results.

**5** ▶ This information is to be released for the purpose of:

- Continuation of care
- Treatment in the facility indicated above
- Processing of my insurance claim
- Application of insurance or state/federal funding programs
- Legal services
- Other \_\_\_\_\_ (Please specify other purpose)

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the clinic office manager. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: . \_\_\_\_\_ If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 42.164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the clinic office manager.

**6** Signature/Date Required X  
Signature of Patient; Parent/Guardian of Minor or Legal Representative

X  
Contact Telephone Number

X  
Relationship to Patient or Title of Legal Representative

X  
Date of Signature

Witness Signature

Date of Witness Signature