PARADIGM HEALTH SYSTEM
A NEW DIRECTION IN HEALTHCARE

* 4610677w3401 A-HIPAA

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:		**DOB:**
Address:		**SSN:**
City:	**State:**	**Zip:**

Entity Requesting Records	**Provider Authorized to Release Records**		
Paradigm Health System, LLC 64301 Hwy 434 Lacombe, LA 70445 985.882.4500 985.882.4501 fax	Name		
	Address		
	City	State	Zip

This authorization will expire on the following date or event: (If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.)

Date: **Event:**

Purpose of this Disclosure:

PHI and Dates of PHI Authorized for Use or Disclosure

Description	Start Date	End Date
☐ All PHI in the record		
☐ Progress Notes		
☐ Laboratory Tests		
☐ X-Ray Tests / Reports		
☐ History and Physical Examination		
☐ Discharge Summary		
☐ Consultation Reports		
☐ Itemized Billing Statement		
☐ Other:		

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results
[ ] Alcohol, drug or substance abuse treatment
[ ] Psychiatric or mental care / treatment
[ ] Other (specify):

I understand that:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release protected health Information, but if I do, it will no have any affect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have the right to receive a copy of this form after I sign it.

Signature of Patient:	**Date**
Signature of Patient's Representative (if necessary):	**Date**
Personal Representative's Relationship to Patient:	