PATIENT LABEL

Authorization to Disclose Health Information

1. I,___________________________________, DOB____________________, authorize OMEGA HOSPITAL, LLC, to use or disclose the above-named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure of the indicated information:
   Name: Omega Hospital, LLC Phone #: (504)-832-4200 Fax #: (504) 832-4209
   Address:2525 Severn Avenue, Metairie, LA 7002
   For the purpose of: ____

3. The type and amount of information to be used or disclosed is as follows (check all that apply; include dates where appropriate):
   ☐ Problem list ☐ Medication list ☐ List of allergies ☐ Immunization record
   ☐ History and Physical (most recent) ☐ Most recent Discharge Summary
   ☐ Laboratory results from (Date)___________to (Date) ________________
   ☐ X-ray and imaging report from (Date)___________to (Date) ________________
   ☐ EKG
   (Please specify if "Report Only" is needed) ____________________________________
   ☐ Mammogram ☐ CT of_______________ ☐ MRI of _______________________
   ☐ ULTRASOUND of_________________ ☐ XRAY of _____________________
   ☐ Consulting reports from____________________________(Doctor's name)
   ☐ ENTIRE RECORD ☐ Other: ____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). It may also include information about behavioral health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:
   IF INFORMATION IS RELEASED TO A THIRD PARTY WHO IS NOT A HEALTHCARE PROVIDER, I UNDERSTAND THAT THE INDIVIDUAL AND/OR ENTITY MAY NOT BE REQUIRED BY LAW TO SAFEGUARD THIS INFORMATION.
   Name:____
   Address:____
   For the purpose of: ☐ Referral to Specialist ☐ Change of Doctor/Provider ☐ Personal ☐Other: ___________________

6. 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 health information management department. 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.

7. 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 in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information that carries with it the potential for 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 Privacy Officer @ (504) 832-4200.

____ ______________________________
Signature of Patient or Personal Representative **Date**

____ ______________________________
If Person Representative/ Relationship to Patient **Signature of witness**