Policy and Protocol for Release of Medical Records

If you need a copy of your medical records, you will need to submit a written request for a medical records release. Records will be ready within 5-7 business days. There will be a charge for your requested records as calculated by the rates below. Our office will contact you with the amount due once your records are ready to be picked up.

Records will be released to another physician's office with our receipt of a medical records request signed by the patient at no charge.

According to Louisiana Revised Statutes state that medical facilities (other than hospitals) are allowed to charge for copying medical records requested by patients, attorneys, subpoena, etc. at the following rates.

$1.00 per page for the first 25 pages
$0.50 per page for the next 475
$0.25 per page thereafter

+$7.50 processing fee

As a courtesy to our patients, we have elected to place a limit on the total amount charged to patients needing their records. The total amount will not exceed $20.00 and the above scale will be applied for records less than 20 pages.

If you need further assistance or information, please do not hesitate to contact our administrative office: (225)924-2020

I have read and understand the above policy regarding release of my medical record information.

____ ________________

Patient Signature Date

2290 S. Range Ave
DenhamSprings,LA 70726
Completion:____________________
Phone: (225)665-2019 / Fax: (225)665-2089

FOR OFFICE USE ONLY
Method of

Date: ______________ Emp Init: ___________

AUTHORIZATION TO PROTECTED HEALTH INFORMATION

(PLEASE PRINT)

Patient Name: ____ **Date of Birth**: ________________

Address: ___________________________________ **Phone**:________________ **SS#**: xxx - xx - ______

By my signature below, I authorize medical information for the above patient as described in this form to be released

FROM: ____**FAX#**:__________________________________

TO: ____**FAX#**:__________________________________

From: (date) __________________________________ **To**: (date) __________________________

☐ **Complete Health Record** ☐ **Diagnosis & Treatment Plan** ☐ **Progress Notes & Photographs**

☐ **Other:** ____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release:
I understand that if my medical information contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, or reference to HIV/AIDS testing or treatment, and/or any other sensitive information, I agree to release. ☐ Yes ☐ No

Right to Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization. This authorization may be revoked at any time by submitting a written notice sent to Williamson Eye Center, 550 Connell's Park Lane, Baton Rouge, LA 70806.

This authorization is good for: ☐ **30 Days** ☐ **90 Days or** ☐ **Until I Revoke In Writing.**

Re-Disclosure:
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of patient or Personal Representative Who May Request Disclosure:
I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if Healthcare services are being provided to me for the purpose of providing information to a third-party (e.g. fitness for work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect the protected health information to be used and/or disclosed. I hereby release and discharge Williamson Eye Center of any liability and the undersigned will hold Williamson Eye Center harmless for complying with this authorization.

Signature: ____ Date: ___________________

Relationship (if not signed by patient): ___________________________