Authorization for the Use and Disclosure of Protected Health Information

Please send completed form to Acadian Health Attn: Medical Records
P.O. Box 98000 - Lafayette, LA 70509-8000
Email: medicalrecords@acadian.com

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____/_____/_____

Address: _____ **Phone #:** _____

City: _____ **State:** _____ **Zip:** _____ **SS#:** _____

Email: _____

INFORMATION TO BE RELEASED

Treatment Dates: _____/_____/_____ to _____/_____/_____

Types of Records: ☐ Medical Record ☐ Billing Record ☐ Both ☐ Other: _____

REASON FOR RELEASE OF INFORMATION

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other: _____

I hereby authorize Acadian Health, Inc. to use or disclose my protected health information as described in this authorization to:

Name or Company: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

Phone #: _____

SELECT PREFERRED DELIVERY METHOD

☐ MAIL ☐ SECURE EMAIL

_____ **(Initial)** I acknowledge, and hereby consent to such, that the release information may contain alcohol and drug abuse, psychiatric, HIV or genetic information.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand I may revoke this authorization at any time by requesting such of Acadian Health, Inc. in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A copy of this authorization will stand as the original.

This authorization expires on the following date: _____/_____/_____

*If an expiration date is not specified this authorization will expire (12) months from the date on which it was signed.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____

Signature of Patient or Patient's Legal Representative *Date*

_____ _____

Printed Name of Patient or Patient's Legal Representative *Relationship to Patient*

Photo identification should be attached to this authorization.