Authorization to Release or Obtain Health Information
Start Community Health Centers

Patient Name:		DOB:	
Address:		City, State, ZIP:	

I authorize all Start Community Health Center locations including:

235 Civic Center Blvd. / Houma, LA 70360 / (P) 985-333-2020 (F) 985-851-0162
2300 S. Galvez Street / New Orleans, LA 70125 / (P) 504-332-5713 (F) 504-558-9599
2150 General Pershing Street / Mandeville, LA 70448 / (P) 985-951-4716 (F) 985-951-4706
1505 N. Florida Street / Covington, LA 70433 / (P) 985-900-1626 (F) 985-867-1768
312 E Bayou Road / Thibodaux, LA 70301 / (P) 985-266-0444 x2660 (F) (985) 275-4737
153 N 17th Street / Baton Rouge, LA 70802 / (P) 225-235-7734 x7734 (F) 225-408-1310

☐ **To Release to and Receive from:** ☐ **To Release Only to:** ☐ **To Receive Only from:**

Name:		Relationship:	
Address:		City, State, ZIP:	
Phone:		Fax:	

The specific purpose of this authorization is indicated in the box(es) below. Check all that apply:

☐ Continuity of Care ☐ Changing Providers ☐ Research-Related Treatment ☐ Personal ☐ Program Eligibility/Entry ☐ MR/DD Services
☐ Legal Investigation/Action ☐ Creating health information for disclosure to third party ☐ Providing information about my treatment
☐ Other:

Physical Health Information ☐ **Not Applicable**
I authorize the following Protected Health Information to be released or obtained from as indicated above. Check all that apply:

☐ Entire Record	☐ X-Ray Reports	☐ Diagnostic Imaging/Reports	☐ Dental Services
☐ Progress	☐ Surgical Reports	☐ Laboratory Results	☐ Primary Care
☐ Immunizations	☐ Hospital Records including Reports	☐ Medical History	☐Other:
☐ Treatment/Tests	☐ Diagnosis	☐ Annual Physical Exam	
☐ Medical History/Screening/Evaluation	☐ Assessment	☐ Prescriptions/History	

Addiction and Mental Health Information ☐ **Not Applicable**
In compliance with state and/or federal laws which require special permission to release otherwise privileged information, release the following records:

☐ Alcoholism Records	☐ Discharge Summary	☐ Drug Use Records	☐ Records with psychotherapy notes
☐ Alcohol Tests	☐ STD & HIV Records	☐ Attendance	☐ Records without psychotherapy notes
☐ Drug Tests	☐ Medical Records	☐ Aftercare Records	☐ Other:
☐ Dates of Care	☐ Prescriptions	☐ Lab Reports	
☐ Treatment Plan / Recommendations	☐ Intake Assessment	☐ Genetics	
☐ Vocational Rehabilitation	☐ Psychiatric Evaluation	☐ Individual / Group Notes	

Intellectual and Developmental Disability Information ☐ **Not Applicable**
I authorize the following Protected Health information to be released or obtained from as indicated above. Check all that apply:

☐ Entry Documentation ☐ Psychological Evaluation ☐ Statement of Approval/Denial ☐ Behavior Support Plan ☐ Plan of Care/Support
☐ Other:

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: ☐ Upon discharge ☐ Other:
I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I give START permission to download my electronic prescription history from an online pharmacy clearing house.

Patient Signature / Date Authorized Representative Signature / Relationship / Date