MINT HEALTH
Authorization To Release Medical Records

PATIENT INFORMATION:

Name (print)

____ DOB____________________ SSN_____________________

RECORDS TO BE RELEASED TO:

Provider or Recipient

____ Phone #____________________ Fax #__________________

Address____

RECORDS TO BE RELEASED FROM:

Mint Health/ Dr. Elizabeth Buchert, MD Phone # 225-250-1025 Fax # 225-367-1108
500 Rue de la Vie, Suite 401 Baton Rouge, LA 70817

INFORMATION TO BE RELEASED:

Dates of Service: __________________ through _____________________

____ Complete Health Record ____Lab Results ____ Imaging Reports

_________________________________Specific Information (please specify)

PURPOSE OF REQUEST:

____ Release self of care from Mint Health/Dr. Buchert ____ Insurance Purposes _____Other

PATIENT AUTHORIZATION:

I understand that my records may contain formation regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)
____Drug/Alcohol abuse/treatment & diagnosis ____Sexually Transmitted Diseases
____HIV/AIDS diagnosis/treatment/testing ____Mental Illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I can inspect or copy the protected health information to be used or disclosed. I authorize Mint Health to use and disclose the protected health information specified above. I understand that once the records I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

Signature:____ Date________________