* Return today or Mail box 134

# LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - Shreveport, La.

Louisiana State University
Health Sciences Center
Student Health
Hospital (8th Floor) H-8-8
P. O. Box 33932
Shreveport, LA 71130-3932

ADDRESSOGRAPH STAMP

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

All information that has been gathered on an individual is personal and private. You are not required to release this information. I understand that LSUHSC will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. Such information cannot be released without authorized written permission, except as required by law.

I understand that the information in the record of:

X

| Name: (1) | | DOB |
|---|---|---|
| Address: (1) | | |
| City: (1) | State: (1) | Zip Code: (1) |

is personal and private. HOWEVER, I GIVE MY PERMISSION FOR:

| Name: (2) Louisiana State University Health Sciences Center | | |
|---|---|---|
| Address: (2) P.O. Box 33932 | | |
| City: (2) Shreveport | State: (2) LA | Zip Code: (2) 71130-3932 |

TO RELEASE TO:

X

| Name: (3) Shriners Hospital for Children | | Phone: (3) 318-222-5704 |
|---|---|---|
| Address: (3) 3100 Samford Ave. | | |
| City: (3) Shreveport | State: (3) LA | Zip Code: (3) 71103 |

THE FOLLOWING SPECIFIC INFORMATION:

X

(4) All TB Test Results

(5) I understand that I have the right to refuse to disclose HIV test results.
I ☐ **DO NOT AUTHORIZE** release of HIV test results.

The above listed information is to be released for the specific purposes of:

X

(6) Volunteer Activities at Shriners Hospital

I understand that my permission to release this information may be canceled at any time except when the information has already been released. My permission to release this information will expire: (7) ____/____/____. I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

The undersigned certifies that he/she is the parent/guardian/representative of the person listed above and has the legal authorization to sign on behalf of the person, whether by court order, or by operation of law.

| X (10) Witness | Date X | X (8) Patient/Client (Including Minor) | Date X |
|---|---|---|---|
| (10) Witness | Date | (9) Parent, Guardian or Custodial Agency | Date |