



Authorization for the Use and Disclosure of Protected Health Information

Please send completed form to Safety Management Systems Attn: Medical Records
P.O. Box 98000 - Lafayette, LA 70509-8000
Email: smsmedicalrecords@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 Safety Management Systems, Inc. and/or its subsidiaries 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 Safety Management Systems, Inc. and/or its subsidiaries 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.