SUBJECT: Disclosure Authorization to Gulf Coast Teaching Family Services, Inc. by Another Entity	REFERENCE: QE
DEPARTMENT: Gulf Coast Teaching Family Services, Inc.	PAGE: 1 OF: 4
	EFFECTIVE:
APPROVED BY:	REVISED:

AUTHORIZATION FOR THE DISCLOSURE OF INFORMATION TO Gulf Coast Teaching Family Services, Inc.
BY ANOTHER ENTITY

At the request of Gulf Coast Teaching Family Services, Inc., Client hereby authorizes

_____

N**ame of other covered entity maintaining the protected health information**

to disclose

_____

specific description of the information to be disclosed]

"protected health information" to Gulf Coast Teaching Family Services, Inc. for the following purpose(s):

_____

Provide description of each purpose of the requested disclosure.

Client hereby acknowledges that he/she understands that treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on his/her signing of this Authorization. However, Gulf Coast Teaching Family Services, Inc. may condition the provision of health care that is solely for the purpose of creating protected health information on Client's signing of this Authorization, and Gulf Coast Teaching Family Services, Inc. may condition the provision of research-related treatment on Client's signing of this Authorization for the use and disclosure of protected health information created for research that includes treatment of the individual.

Client may refuse to sign this Authorization if he/she so chooses.

The Gulf Coast Teaching Family Services, Inc. may use or disclose such protected health information only until

_____

Enter an expiration date or **expiration event relating to the individual or purpose of the use or disclosure**.

At all times, Client retains the right to revoke this Authorization, except if the Authorization was obtained as a condition of obtaining insurance coverage. Such revocation must be submitted to the Gulf Coast Teaching Family Services, Inc. in writing. The revocation shall be effective *except* to the extent that the Gulf Coast Teaching Family Services, Inc. has already used or disclosed information in reliance on the Authorization. Client may revoke this Authorization by signing in the appropriate space below or by sending a letter describing such revocation to the Chief Privacy Officer at:

Kim Kennedy, Director of QA Operations
5850 Florida Boulevard

Baton Rouge, LA 70806

Telephone: 225-201-0696
Fax: 225-201-1793
Email: kim_kennedy@gctfsbr.org

Client has been informed and understands that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of such information, and, at that point, the information may no longer be protected under the terms of this agreement.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE CLIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE CLIENT TO SIGN THIS SEALED [SEALED SIGNATURES ARE OPTIONAL] DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS

Date Time AM/PM

Signature of Client Please print name

Signature of witness Please print name

Person Signing on behalf of Client* Please print name

*Please explain Representative's Relationship to Client and include a description of Representative's Authority to act on behalf of Client:

Revocation

I, _____
Client Name

hereby revoke this authorization and the releases and disclosures of my personal health information as described herein.

_____ _____
Date Time AM/PM

_____ _____
Signature of Client Please print name

_____ _____
Signature of witness Please print name

_____ _____
Person Signing on behalf of Client* Please print name