



Name:	JEFFREY THOMAS BODIN
Date of Birth:	22-May-1997
Gender Identity:	Male

Documents

9/10/2018 - Release of Information Authorization LSU Healthcare Network

FollowMyHealth

Authorization Release of Information

First Name: JEFFREY

Middle initial:

Last Name: BODIN

I, BODIN, JEFFREY authorize LSU Healthcare Network to release any and all healthcare information about me to my FollowMyHealth personal health record for my own uses and purposes. I acknowledge that such healthcare information may include the following: x-rays, clinical diagnosis, histories of present illnesses, immunizations, allergies, prescription drug information, laboratory results, diagnostic screening and testing, clinical procedures, medical research, clinical trials, billing, account, and insurance information.

I acknowledge that such healthcare information may include information regarding mental health screenings and/or treatment, including psychotherapy notes; HIV/AIDS, infectious disease, sexually transmitted infection testing, screening, diagnosis, and/or treatment; genetic testing; history of domestic violence, child abuse, and/or family abuse; and, substance/alcohol use and treatment history.

I acknowledge that with this authorization LSU Healthcare Network may disclose any information or records (within the scope of the authorization) that LSU Healthcare Network has received about me from other healthcare Practices or facilities. LSU Healthcare Network may, within its discretion, withhold from disclosure any of the above information as permitted or required by law.

Access to treatment or services may not be denied to me if I decline to sign this Authorization or revoke my Authorization. However, without this Authorization, my Practice will not electronically release my healthcare information to my FollowMyHealth personal health record. I may revoke this Authorization at any time. Such revocation will promptly take effect except to the extent that LSU Healthcare Network already has acted based on this Authorization.

I may revoke this Authorization by removing LSU Healthcare Network as a health care Practice with which I want to be connected on my FollowMyHealth account or providing my request to LSU Healthcare Network. However, I acknowledge that data previously submitted by LSU Healthcare Network as authorized by me prior to my subsequent revocation of this Authorization will remain in my Follow My Health account. I understand that I may delete my FollowMyHealth account any time.

This authorization shall end upon the earliest of: a) the termination of the connection between my healthcare Practice and my FollowMyHealth Account; b) upon my written request submitted to support@followmyhealth.com; or c) 12 months from the date of execution of the Authorization.

For Authorized Representatives of Patients younger than 18 years old: This Authorization shall expire upon the earliest of: (1) the date the minor reaches the age of 18; or (2) the date FollowMyHealth receives written revocation from the minor, as an emancipated minor with legal authority to manage his/her own healthcare.

I understand that the information submitted to my FollowMyHealth account is subject to the privacy and security protections of applicable Federal and State laws. I further understand and acknowledge that the manner in which FollowMyHealth protects my personal information is detailed in the FollowMyHealth Privacy Policy and the FollowMyHealth Terms of Use.

I understand that LSU Healthcare Network is not responsible for the security of data stored in the FollowMyHealth database, and that the owners of FollowMyHealth are responsible for ensuring the security of the data stored in FollowMyHealth.

I have the right to receive a copy of this Authorization and may do so by clicking [Print] above.

Signed on 09/10/2018

Please complete the following information:

BODIN, JEFFREY

05/22/1997

If signing on behalf of a Patient, please complete the following:

Relationship to Patient: [Place "x" in the appropriate box below]

Patient

Parent/Guardian/Other Legal Representative

By clicking [I ACCEPT], I acknowledge and agree to the terms of this Authorization.

DISCLAIMER: This information is supplied from the patient's medical record via a patient portal. The medical provider is listed as the source. Items with a source of 'Patient-Entered' were added by the patient. This record may not be complete or up to date, and should not be used for providing medical advice. For an official copy of the individual's medical record, the patient (or custodian) must contact their medical provider.

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