



AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

All areas designated by an arrow are REQUIRED for valid authorization.

PLACE PATIENT'S LABEL HERE

0445573

1 I authorize Children's Hospital, New Orleans / to receive from to release to

INFORMATION REGARDING:

2 Jeffrey Thomas Bodin
SPECIFIC NAME OF HOSPITAL, PHYSICIAN, SERVICE AGENCY OR THIRD PARTY

3 528 Beau Chene Dr Mandeville LA 70471
STREET ADDRESS CITY STATE ZIP CODE

Mail Email : jeffreybodin713@gmail.com
Patient's Name: Jeffrey Thomas Bodin
Patient's Date of Birth: 05/22/1997
Service Dates: 01/01/2008 - 01/01/2019

4 I AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION:

<input checked="" type="checkbox"/> Abstract (H&P, OP, DS, Rad, Lab, Con)	<input checked="" type="checkbox"/> Complete Hospital	<input checked="" type="checkbox"/> History and Physical Report (H&P)
<input checked="" type="checkbox"/> Adolescent Behavioral Health	<input checked="" type="checkbox"/> Consultation(s) (Con)	<input checked="" type="checkbox"/> Lab Reports (Lab)
<input checked="" type="checkbox"/> Audrey Hepburn CARE Center	<input checked="" type="checkbox"/> Diagnosis, including alcohol and drug abuse	<input checked="" type="checkbox"/> Radiology Results (Rad)
<input checked="" type="checkbox"/> Billing Information	<input checked="" type="checkbox"/> Discharge Summary (DS)	<input checked="" type="checkbox"/> Results of HIV testing
<input checked="" type="checkbox"/> Clinic Notes	<input checked="" type="checkbox"/> Emergency Room Record (ER)	<input checked="" type="checkbox"/> Report of Operation (OP)
<input checked="" type="checkbox"/> Complete Clinic Record		
<input checked="" type="checkbox"/> Other: <u>Any records relating to cancer treatment 2008.</u>		

5 I AUTHORIZE the release of HIV test results. I understand I am authorized by law to allow or refuse to allow the release of HIV Test Results. An HIV Test Result is the original document, or copy thereof, transmitted to the medical record from the laboratory or other testing site with the result of an HIV-related test. It does not include any other note, notation, diagnosis, report, or other writing or document.

I AUTHORIZE the release of HIV test results. I DO NOT AUTHORIZE the release of HIV test results.

6 This information is to be released for the purpose of:

Continuation of care Treatment in the facility indicated above Legal services Academic Case Study/Journal Story

Insurance request Other (please specify purpose) Records Purposes

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 42.164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the hospital's Privacy Officer.

7 Patient, Parent/Guardian of Minor or Legal Representative Signature X Jeffrey Bodin Phone Number Home / Cell (985) 520-4713 / (985) 272-8989

Relationship to Patient or Title of Legal Representative mother Date MM/DD/YY 5/11/18 Time 00:00 am/pm 8:20 PM

Witness Signature X Yvonne D.R. Bodin Date MM/DD/YY 5/11/18 Time 00:00 am/pm 8:20 AM PM

Electronic Media Requested Language Line: Declined Interpreter's # _____

CD Processed Name: _____ Date: _____

Scan to PT Auth



Louisiana
Don't Stop Learning

PERSONAL DRIVER'S LICENSE



UNDER 21 UNTIL
05-22-2018
DOB 05-22-1997
ISSUE DATE 04-05-2016
AUDIT 7048
OFFICE 299
PARISH 52
SEX M
HGT 5' 07"
WGT 118
EYES BROWN

BODIN
JEFFREY THOMAS
528 BEAU CHEVE DRIVE
MANDEVILLE, LA 70471-2000

LICENSE NO.	CLASS	EXPIRATION DATE
01086293	E	05-22-2022

ENDORSEMENTS
NONE

REGISTRATION
61

CC Payment Receipt

Transaction Status:	Approved
Transaction Date and Time:	5/26/2018 8:45:59 PM
Transaction Reference No.:	1293999
Approval Code:	0001250353
Order Number:	21776295
Charge Amount:	\$6.50
Credit Card Number:	XXXXXXXXXXXX1006
Credit Card Holder:	Jeffrey T Bodin