130 DeSiard Street, Suite 355, Monroe, LA 71201
Fax No. (318) 807-1039

Authorization to Release or Obtain Health Information

(including written, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid ID# or Social Security #:

I authorize:

Name:____

Mailing Address:____ City,

State, Zip Code:____ Relationship:_

Telephone Number:_______________________________

☐ **TO RELEASE INFORMATION TO** **OR** ☐ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name:____ Mailing

Address:____ City, State,

Zip Code:____ Relationship:_

Telephone Number:_______________________________

The **Purpose of this Authorization** is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action ☐ Changing Physicians

☐ Research Related Treatment ☐ Creating Health Information for Disclosure to Third Party ☐ Other_________________

I authorize the release of the following protected health information.

(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Treatments or Tests

☐ Prescriptions ☐ Immunizations ☐ Hospital Records including Reports ☐ Laboratory Reports

☐ X-Ray Reports ☐ Other:____

The following types of information will be released UNLESS you place your initials in the spaces provided:

_______Alcohol/Drug Treatment Records _______Mental Health Treatment Records _______Vocational Rehabilitation

______ HIV (AIDS) Test results _______ Sexually Treatment Records ______Genetic Testing

______ Psychotherapy Notes Other:_____________________

This authorization shall expire on ____________________(date or event) and is needed for the period beginning ________________and ending __________________.

I understand that if I do not specify an expiration date, this authorization will expire twelve (12) months from the date on which it was signed. I acknowledge that I have read this form.

_______________________________________ _____________________ __________

Signature of Individual or Personal Representative Authorized by Law Relationship to Patient Date

_______________________________________ _______________

Signature of Witness (if signed with an ("X") or mark) Date