martha e. stewart, md, llc
dermatology

martha e. stewart, md
amy t. ananth, md
board certified dermatologists

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____
(LAST, FIRST)

I HEREBY REQUEST AND AUTHORIZE:

- ❒ **Martha E. Stewart, MD**
- ❒ **Amy T. Ananth, MD**

4060 Lonesome Rd
Mandeville, LA 70448
P) 985-727-7701
F) 985-727-7375

TO RELEASE MY PROTECTED HEALTH INFORMATION TO:

_____

_____

Purpose of this Disclosure: _____

INFORMATION TO BE DISCLOSED (check all that apply): Start Date End Date

- ❒ All Medical Records.....
- ❒ Progress Notes.....
- ❒ Laboratory Tests.....
- ❒ X-Ray Tests / Reports.....
- ❒ History and Physical Examination.....
- ❒ Discharge Summary.....
- ❒ Consultation Reports.....
- ❒ Other:

The following information will be released when included in the above information unless you indicate otherwise: AIDS or HIV test results, Alcohol, drug or substance abuse treatment, Psychiatric or mental care treatment, and/or other (please specify):

_____

I UNDERSTAND THAT:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment, or enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. A photographic or faxed copy of this authorization shall be valid as the original.
6. This consent shall remain in effect until six months from date of signature.

Signature of Patient: _____ Date: _____

Signature of Representative, if patient is a minor: _____ Date: _____

Relationship of Representative to patient: _____