



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

I HEREBY REQUEST AND AUTHORIZE:

TO RELEASE MY PROTECTED HEALTH INFORMATION TO:

Martha E. Stewart, MD

Olivia A. Gioe, MD

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

Purpose of this Disclosure: _____

INFORMATION TO BE DISCLOSED (check all that apply):	Start Date	End Date
<input type="checkbox"/> All Medical Records.....		
<input type="checkbox"/> Progress Notes.....		
<input type="checkbox"/> Laboratory Test.....		
<input type="checkbox"/> X-Ray Tests / Reports.....		
<input type="checkbox"/> History and Physical Examination.....		
<input type="checkbox"/> Discharge Summary.....		
<input type="checkbox"/> Consultation Reports.....		
<input type="checkbox"/> 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: _____