martha e. stewart, md
olivia a. gioe, md
harley davis, md
board certified dermatologists

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**	**4060 Lonesome Rd**
__ **Olivia A. Gioe, MD**	**Mandeville, LA 70448**
__ **Harley Davis, MD**	**P) 985-727-7701**
	F) 985-727-7375

Purpose of this disclosure: ____

Information to be disclosed (check all that apply): Start Date End Date

_ All Medical Records ....
_ Progress Notes ....
_ Laboratory Test ....
_ 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 the 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 policy 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: ____