AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

All information that has been gathered on an individual is personal and private. You are not required to release this information. I understand that the health care provider will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. Such information cannot be released without authorized permission, except as required by law.

Patient Name: _____
Last Name First Name Middle Initial

PatientAddress: _____
Street City State Zip Code

Home Telephone ( ) _____ Date of Birth _____

SSN: _____

I authorize _____
Name of the Physician, Facility, Other, or Self Mailing Address City, State, Zip

To release to E. Ray Kethley, Attorney at Law, 6121 Line Avenue, Shreveport, Louisiana 71106.

The following specified information: (Place a mark in the box and specify any dates in the blank line provided.)

☒ Entire Record: _____ ☒ Clinic Notes: _____

☒ Lab: _____ ☒ Correspondence: _____

☒ X-Ray: _____ ☒ Records from other facilities:

☒ Other: _____ _____

Purpose for disclosure: ☒ Medical Care ☒ Legal
☒ Insurance ☒ Personal ☒ Other _____
I authorize the disclosure of the information described above via: ☒ Copy
☒ Facsimile ☒ Verbal ☒ Written

READ THE FOLLOWING CAREFULLY BEFORE SIGNING

By signing this form, I understand that I am authorizing the release or disclosure of the requested health information as marked above in accordance with any specifications I have made. I also understand that the health information to be released may include reference to treatment or history of: **1) Mental or behavioral heath, 2) Alcohol or drug abuse, 3) HIV and/or AIDS.**

** *Initial in the space provided* ***if you do not authorize*** *the release or disclosure of this information:* _____

- This authorization will expire one (1) year from the date it is signed by the patient or legal representative.

- The patient or legal representative may revoke this consent at any time with written request.

- Any health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the healthcare provider, APMC or the federal privacy regulations.

_____ _____

Patient or Legal Representative Signature Date Signed

_____ _____

Witness Signature (Only for a Legal Representative) Date Signed