STEWART

Family Medicine & After-Hours

PO Box 1567
Livingston, LA 70754
225.686.1114 FAX: 225.686.1166

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____

Patient's DOB: _____ **SSN:** _____ **Phone:** _____

Address: _____

I authorize Stewart Family Medicine to release the following medical records to the person listed below. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law. Identification must be provided by the authorized recipient of my medical records.

Medical Records to be Released:

_____
_____
_____
_____
_____

Release Records to (Please Print): _____

Phone: _____ **DOB:** _____

I understand that this authorization shall remain in effect until a written request to revoke the authorization is sent to Stewart Family Medicine by me. I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization.
I understand and agree to its terms.

Signature of Patient: _____ **Date:** _____