Rue de Santé
Women's Center
Obstetrics & Gynecology

*Ph. (985) 652-2441  Fax (985) 652-4167*

# Authorization to Release Medical Records

Patient's Name _____

Date of Birth_____ Phone # _____

I, _____, authorize _____
Phone/Fax #_____to disclose a copy of the specific health and medical information identified below to Rue de Sante Women's Center, 301 Rue de Sante', Laplace, La 70068.

I,_____, authorize Rue de Sante Women's Center to disclose a copy of specific health and medical information identified below to _____
(Provider Address:) _____
_____

By checking the space below, I specifically authorize for the following health information and/or medical records:

___The entire medical record
___Office chart notes only
___Laboratory reports only
___Pathology reports only
___Include billing statements
___Other:_____

The purpose of this release of information:

_____

**(OVER)**

I understand that, if the person or organization receiving the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance requirements.

I also understand that the person I am authorizing to use/or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of information to be used and/or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire in 1 year from the date of signing.

_____ _____

(Signature of Patient or Legal Guardian) (Date)

_____

(Relationship to Patient)