

# Stewart Family Medicine & After-Hours

PO Box 1567  
Livingston, LA 70754  
(225)686-1114  
Fax (225)686-1166

## AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION FROM STEWART FAMILY MEDICINE

Patient: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_ (patient or guardian), authorize

**Stewart Family Medicine & After Hours to release my Protected Health Information to:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

### **Information to be Released—Covering the Periods of Health Care**

Date(s) of Treatment: \_\_\_\_\_

#### ***Records to Include:***

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Complete health record  | <input type="checkbox"/> Diagnosis & treatment codes | <input type="checkbox"/> Discharge summary  |
| <input type="checkbox"/> History & physical exam | <input type="checkbox"/> Consultation reports        | <input type="checkbox"/> Progress Notes     |
| <input type="checkbox"/> Laboratory test results | <input type="checkbox"/> X-ray reports               | <input type="checkbox"/> X-ray films/images |
| <input type="checkbox"/> Immunization records    | <input type="checkbox"/> Itemized bill               | <input type="checkbox"/> Other, specify:    |

### **General Authorization**

I understand and acknowledge that this general authorization allows the health care facility to release all or part of the records indicated above for the purpose stated. I understand that, on occasion, information may be released by telephone or fax.

This consent is valid for 90 days, unless revoked by me in writing before the release of the above designated information.

I read this form, or had it read to me and I understand it. I was given an opportunity to ask questions. Any question I asked was answered to my satisfaction. My signature below indicates my voluntary authorization for both general and special release of information.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signed Authorization: \_\_\_\_\_ Date: \_\_\_\_\_