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 TO STEWART FAMILY MEDICINE

Patient: _____

SS#: _____ DOB: _____

I, _____ (patient or guardian), authorize release of medical:

Records From:	**Records To:**
_____	_____
_____	_____
_____	_____
FAX #: _____	FAX #:_____

Information to be Released—Covering the Periods of Health Care

Date(s) of Treatment: _____

Records to Include:

☐Complete health record	☐Diagnosis &treatment codes	☐Discharge summary
☐History & physical exam	☐Consultation reports	☐Progress Notes
☐Laboratory test results	☐X-ray reports	☐X-ray films/images
☐Immunization records	☐Itemized bill	☐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: _____