THE FAMILY DOCTORS
8383 Millicent Way Shreveport, LA 71115
Phone 318/797-6661 Fax 318/795-8512

Authorization to Release/Obtain Information

Full Name _____
LAST FIRST MI MAIDEN
Date of Birth: _____ Social Security Number: _____
Daytime Telephone Number:_____ Evening:_____
Address:_____
City: _____State:_____ Zipcode: _____

I, _____, understand that the information contained in
(Requestor)
_____ medical record is confidential. However, I
(Patient's name)
specifically give my consent for The Family Doctors to

_____ Release _____ Obtain

the following medical information:

_____History & Physical Exam
_____Laboratory, X-ray Reports
_____Social History
_____Psychological
_____Other: _____
_____Drug and Alcohol Information
_____HIV Information
_____Discharge Summary

to/from: _____
(Name)
_____
(Address)
Dates of Service From: _____ To: _____

The above listed information is to be disclosed for the specific purpose of:

- Changing Physicians
- Consultation
- Continuing Care
- Disability
- Legal
- Workers' Compensation
- School
- Insurance

Patient/Representative Initials _____

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I understand that this authorization may only be used for the disclosure listed above, and that the authorization will expire 60 days after I have signed it. I understanding that it will become a part of medical record.

I understand that I may revoke this authorization at any time by notifying The Family Doctors in writing, and that it will be effective on the date notified except to the extent that action has already been taken in reliance upon it.
I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and will no longer be protected by Federal privacy regulations.

I understand that my healthcare and payment for my healthcare will not be affected if I choose not to authorize the release of information.

I understand that I may see and obtain a copy of the records described in this authorization upon my request. Additionally, I may receive a copy of this authorization upon request.

I understanding that The Family Doctors may receive compensation for the use or disclosure listed on this authorization.

_____ _____
Patient/Representative Signature Date

_____ _____
Records Disclosed by (Authorized Personnel Only) Date

REVOCATION - SIGN THIS SECTION ONLY IF YOU WANT TO REVOKE AUTHORIZATION

I hereby revoke this authorization.

_____ _____
Patient/Representative Signature Date