St. Landry Family Healthcare

Elliot Myers, APRN, FNP-C

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Address: _____

_____

Date of Birth: _____

Phone: _____

Last four SSN: _____

I authorize: Provider/Entity: _____

Address: _____

Phone/Fax: _____

To disclose/release the following information:

____ All records
____ Office notes (previous 2 yrs.)
____ Laboratory/pathology records (previous 3 yrs.)
____ Radiology records (previous 3 yrs.)
____ Billing records
____ Pharmacy/prescription records
____ Other: _____

Please send the records listed above to:

St. Landry Family Healthcare
6633 Highway 10
Washington, LA 70589
P: 337.826.7702 | F: 337.623.5788

This authorization shall not be valid for greater than one year from the date of signature.
I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims to orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of Patient (or Patient's Personal Representative) Date

_____
Printed Name of Patient or Representative