LOUISIANA ARTHRITIS & RHEUMATOLOGY
Get the personal attention you deserve.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Requested From:

_____
_____
_____
_____

Release To:

Louisiana Arthritis and Rheumatology
457 Ashley Ridge Blvd, Suite C
Shreveport, LA 71106
Phone (318) 219-7704 Fax (318) 219-7752

Patient Name:_____ DOB: _____

Patient Address: _____

City, State Zip:_____

Protected health information to disclose for treatment dates _____ to

- ❑ Medical Records from last two years
- ❑ Entire Chart
- ❑ MRI Film/Report
- ❑ X-Ray
- ❑ Lab Reports
- ❑ EMG Report
- ❑ Other _____

The above information is disclosed for the following purposes:

- ❑ Medical Care
- ❑ Personal
- ❑ Other _____
- ❑ Legal
- ❑ Insurance

_____I specifically consent that the released information may contain alcohol and drug abuse, psychiatric, HIV
Initials or genetic information.

This authorization shall be in force and effect for two years at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Louisiana Arthritis and Rheumatology** at **457 Ashley Ridge Blvd, Suite C, Shreveport, Louisiana 71106**. I understand that the revocation is not effective to the extent that **Louisiana Arthritis and Rheumatology** has relied on the use or disclosure of the protected health information. I further understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. There are associated fees for providing copies of medical records see: LSA-R.S. 40:1299.96A(2)(b).

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal or state law. I also understand I have the right to refuse to sign this authorization

_____ _____
Signature of Patient or Legal Representative Date

If signed by a legal representative, relationship to patient: _____