LOUISIANA ARTHRITIS & RHEUMATOLOGY
Get the personal attention you deserve.

RELEASE TO:

8508 Line Avenue, Suite C
Shreveport, LA 71106
318.219.7704 PHONE
318.219.7752 FAX

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Requested From: _____ _____

_____ _____

Patient Name: _____ D.O.B. _____

Patient Address: _____City/State/Zip _____

Protected health information to disclose for treatment dates _____to _____

☐ Medical Records (last two years) ☐ X-Ray ☐ Lab Reports ☐ Entire Chart

☐ MRI Film/Report ☐ EMG Report ☐ Other _____

The above information is disclosed for the following purposes:

☐ Medical Care ☐ Legal ☐ Personal ☐ Insurance ☐ Other _____

_____ I specifically consent that the released information may contain alcohol and drug abuse, psychiatric, HIV, or genetic information.
(initials)

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 8508 Line Avenue, Suite C, Shreveport, LA 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 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) (Printed Name) (Date)

If signed by legal representative, relationship to patient: _____