LAKESHORE UROLOGY

Authorization To Release Medical Records/Information

Physician of Facility to Provide Records: _____

Patient's Name: _____ SSN#: _____ DOB: _____

Person to Pickup Records: _____ Relationship: _____

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition(s):

Initial:

_____ Drug Abuse *(if any)*

_____ Substance Abuse *(if any)*

_____Psychological/Psychiatric Condition *(if any)*

_____ AIDS/HIV *(if any)*

Release these records:

1. All medical records at this facility.
2. Only records generated by this facility.
3. Only some portions of records maintained at this facility.

Specify Which Medical Records: _____

EXPIRATION OR REVOCATION OR AUTHORIZATION: I understand that I may revoke this authorization at any time.

USE OF COPIES: A copy of this authorization may be utilized with the same effectiveness as an original.

Name *(Print)*: _____ Date: _____

Signature: _____

Check: _____ Patient _____ Parent _____ Guardian

MAIL OR FAX RECORD TO:

215 E Gibson Street
Covington, LA 70433
Fax: (985) 773-1998

4315 Houma Blvd, Suite 302
Metairie, LA 70006
Fax: (504) 780-2558