PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

Patient Information:

Patient Name _____ Date of Birth _____ Social Security Number _____

Information to be released from: _____
Name of the Designated Facility and/or Provider

_____
Address

_____Phone #_____
City, State, Zip Code

Information to be sent to:

Dr Leonard Kancher
3601 Houma Blvd #300
Metairie, LA 7006
Phone 504-885-7360 Fax 504-885-1360

Information to be released:
_____ All medical records from date of initial evaluation and treatment, to the date you receive this authorization. (Chart notes, billing records, labs, x-rays, etc.)
_____The _____ most recent years of pertinent information (Chart notes, billing records, labs, x-rays, etc.)
_____ Other Specific information (Specific dates of treatment, date range, etc.)

Purpose for which disclosure is being made:

____ Attorney/Legal ____Insurance __**X**___ Doctor _____ Personal ____ Other _____

Protected Records:
_____ I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted disease, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for all of these records to be released.

_____ I want to exclude the following information (check those that apply)
_____ Drug/Alcohol abuse diagnosis/treatment/testing
_____ HIV/ AIDS diagnosis/treatment/testing
_____ Sexually Transmitted Disease diagnosis/treatment/testing
_____ Mental Health/Psychiatric diagnosis/treatment/testing

My Rights:
I understand I do not have to sigh this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing at any time. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

This authorization will expire in 90 days from the date signed.

Signature_____ Date: _____

Parent or Guardian may sign only if patient is 14 years or younger. If signed by authorized representative attach appropriate legal documentation.