Authorization to use or disclose Protected Health Information

I hereby authorize ______________________ (covered entity) to use or disclose the following protected health information (PHI) from the medical records of:

Patient Name: ______________________________________

Date of Birth: _____________________________________

Social Security Number: _________________________

Address: ____

____

Please release records to: Rick Leoni II, M.D.
203 Rue Louis XIV, Suite A
Lafayette, LA 70508
Phone 337-981-2393
Fax 337-981-9470

Disclose the following PHI for treatment dates of ____________ to _______________. Please include physician notes, visual fields, A-scans, X-rays, CT scans, MRI scans, and lab results.

The above information is disclosed for medical care, and insurance purposes.

_______ (Please initial) I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV or genetic information.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Annette Broussard, office manager. I understand that the revocation will not apply to information that has already been released to this authorization.

This authorization shall expire upon this expiration date: ______________________.

I have read the above and authorize the disclosure of the protected health information as stated.

__________________________________ ________________

Signature of Patient / Legal Representative Date