Authorization to Release or Obtain Health Information

Name	Request Date
Mailing Address	Date of Birth
City/State/Zip	Social Security #

(including paper, oral and electronic information)

I authorize:

Name: **LEONI 2MED, LLC / RICK LEONI II, MD / JULIE FOREMAN, MD**

Mailing Address: City, State, Zip Code: **203 RUE LOUIS XIV, SUITE A, LAFAYETTE, LA 70508**

Telephone Number: **337-981-2393** Fax Number: **337-981-9470**

❒ **TO RELEASE Information TO OR ❒ TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.

Name: ____________________

Mailing Address: ____________________

City, State, Zip Code: ____________________

Telephone Number:____________________ Fax Number: ____________________

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❒ Further Medical Care ❒ Personal ❒ Legal Investigation or Action ❒ Changing Physicians
❒ Research related treatment ❒ Creating health information for disclosure to a third party.
❒ Other: (Specify)____________________

I authorize the release of the following protected health information.
(Place an "X"in the box(es) that apply to the information you want released or you want to obtain.)
❒ Entire Record ❒ Medical History, Examination, Reports ❒ Surgical Reports ❒ Treatment or Tests
❒ Prescriptions ❒ Immunizations ❒ Hospital Records including Reports ❒ Laboratory Reports
❒ X-ray Reports ❒ MR/DD Records ❒ Other: ____________________

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

❒ Alcoholism † ❒ Drug Abuse † ❒ Mental Health ❒Vocational Rehabilitation ❒ HIV (AIDS)
❒ Sexually Transmitted Diseases ❒ Genetics ❒ Psychotherapy Notes
❒ Other____________________

This authorization shall expire on ____________________(date or event) and

is needed for the period beginning ____________________and ending ____________________.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read and understand this form.

____________________ ____________________
Signature of Individual or Personal Representative Authorized by Law Date

____________________ ____________________
Signature of Witness *(If signed with an "X" or mark)* Date