

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 / JOE M. GANNON, MD

Mailing Address: City, State, Zip Code: 203 RUE LOUIS XIV, 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