AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)	DOB

ADDRESS	SSN

CITY	STATE	ZIP

PROVIDER AUTHORIZED TO RELEASE THE PHI:	ENTITY RECEIVING THE PHI:
	NAME: DRS. LOUAPRE, KOKEMOR, SARRAT & BRAEDT, LLC
	ADDRESS: 2633 NAPOLEON AVENUE SUITE 400
	CITY: NEW ORLEANS STATE: LOUISIANA ZIP: 70115-6388
	ATTENTION: ☐ Rene A. Louapre, III, M.D. ☐ John J. Kokemor, M.D. Phone: 504-897-3305 ☐ Stephanie L. Sarrat, M.D. Fax: 504-897-3331 ☐ Gary B. Braedt, M.D., Ph. D.

This authorization will expire on the following date or event:

Date: Event:

Purpose of this Disclosure:

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
☐ All PHI in the record		
☐ Progress Notes		
☐ Laboratory Tests		
☐ X-Ray Tests/Reports		
☐ History and Physical Examination		
☐ Discharge Summary		
☐ Consultation Reports		
☐ Itemized Billing Statement		
☐ Other:		

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results
[ ] Alcohol, drug, or substance abuse treatment
[ ] Psychiatric or mental care / treatment
[ ] Other (specify):

I understand that:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time, in writing to the provider authorized to release the protected health information, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have the right to receive a copy of this form after I sign it.

Signature of Patient:	Date:
Signature of Patient's Representative (if necessary):	Date:
Personal Representative's Relationship to Patient:	