INFOSTAT,L.L.C.

A RELEASE OF INFORMATION SERVICE

AUTHORIZATION TO RELEASE INFORMATION

PLEASE TYPE OR PRINT ALL INFORMATION, EXCEPT SIGNATURE

PATIENT NAME_____
Last First Middle

ADDRESS_____
Number Street City State Zip

PHONE (___)_____ SOCIAL SECURITY #_____

MEDICAL RECORD #_____ DATE OF BIRTH_____

DATES OF TREATMENT:_____

I AUTHORIZE_____
Name of Doctor, Medical Facility, etc. *Address: Number Street City State Zip

TO RELEASE MEDICAL INFORMATION FROM MY MEDICAL RECORD TO:

NAME:_____
Name of Doctor, Hospital, etc.

ADDRESS:_____
Number Street City State Zip

DESCRIPTION OF INFORMATION TO BE DISCLOSED: _____
_____
_____

STATEMENT OF PATIENT'S RIGHTS TO REVOKE AUTHORIZATION:
I understand that I may revoke this authorization at any time in writing to the provider authorized to release the protected health information to the address listed above. If I choose to revoke this authorization, I understand that it will not have any effect on any actions taken before the revocation was received by the provider of the information*.

I also understand that if the requestor or the receiver of my protected health information is not a health plan or covered health care provider, the released information may no longer be protected by Federal privacy regulations and may be re-disclosed.

PATIENT SIGNATURE:_____ DATE:_____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE SIGNED.

IF SIGNED BY PATIENT REPRESENTATIVE:
NAME:_____

DESCRIBE RELATIONSHIP / AUTHORITY:_____
_____

PLEASE RETURN BY FAX TO (318)445-6913 OR
MAIL TO PO BOX 12910, ALEXANDRIA, LA 71315