OB/GYN Associates of Shreveport

7941 Youree Drive, Shreveport, La 71105
Ph# 318-797-7941 or Fax 318-797-7991

Authorization to Release or Obtain Health Information

Please check your doctor:

□ Dr. John Waterfallen **□ Dr. EB Robinson** **□ Dr. Marsha Friedrich** **□ Dr. Russell Burlison**
□ Dr. Beth Geneux **□ Dr. Warren West** **□ Dr. Edwin Byrd** *Records Mailed:* ___________

Patient name_______________________________________ Request Date ________________________________

Mailing Address:____________________________________ Date of Birth_________________________________

City/State/Zip:______________________________________ Social Security# ______________________________

□ *RELEASE Information 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:__________________________________

Place an "X" in the box(es) that apply).

□ Consulation □ School □ Legal
□ Changing Physicians □ Continuing Care □ Insurance
□ Worker's Compensation □ Other:____

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.)

Information to be released: Dates:

□ History and Physical exam ___________________
□ Progress Notes ___________________
□ Lab Reports ___________________
□ X-Ray Reports ___________________

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following.
□ Sexually Transmitted Disease □ HIV (Aids) □ Other____

I understand that, this authorization will expire thirty days from the date on which it was signed.

____ ___________________
Signature of Individual or Personal Representative authorized by law Date