LOUISIANA PET/CT Imaging of Lake Charles, LLC

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS INFORMATION

Patient's Name:_____
LAST FIRST MI

Date of Birth:_____ **Telephone Number:**_____
MONTH DAY YEAR

Address:_____
STREET

_____
CITY STATE ZIP CODE

The undersigned hereby authorizes and requests ----------
IDENTITY OF THIRD PARTY/NAME OF
DULY AUTHORIZED REPRESENTATIVE

With access to my medical records for the purpose of review and examination and further authorizes and requests that you provide such copies thereof as may be requested.

The foregoing is subject to such limitations as indicated below:

( ) 1. Confined to record regarding admission and treatment for the following medical condition or injury:

_____

on or about_____at the following facility_____

( ) 2. Covering records for the period from _____to_____
DATE DATE

( ) 3. Confined to the following specified information:_____

_____

( ) 4. Without regard to any limitations placed on dated, history of illness, or diagnostic and therapeutic information, including any treatment, including any treatment for alcohol and drug abuse.

Signature:_____ **Date:**_____
IF SIGNED BY REPRESENTATIVE, STATE
RELATIONSHIP & AUTHORITY TO SIGN

Witness:_____ **Date:**_____

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE.

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