Sinus and Nasal Specialists of Louisiana, LLC

Dr. Christian A. Hall & Dr. Henry P. Barham

Phone: 225-819-1181 Fax: 225-246-8333

**Request and Release for Medical Records**

 Patient's Name Date of Birth Social Security Number

Street Address City State Zip

Home Phone Work Phone Mobile Phone

|  |  |
| --- | --- |
| **Records to be released from:**Facility Name/Address | **Records to be released to:**Facility Name/Address |
| Relationship to patient | Relationship to patient |
| Phone Number: | Phone Number: |
| Fax Number: | Fax Number: |

The undersigned hereby authorizes the release of my health Information:

**Please check all information to be sent:**

|  |  |
| --- | --- |
| 🞎 EKG/Catheterization Reports | 🞎 Emergency Room Records |
| 🞎 History & Physical  | 🞎 Discharge Summary |
| 🞎 Laboratory & Radiological Reports  | 🞎 Outpatient Surgery Records |
| 🞎 Progress Notes/Office Notes | 🞎 Physician's Orders |
| 🞎 Operative & Pathology Reports  | 🞎 Nurse's Notes |
| 🞎 Other(specify):  |

* This Protected Health Information is being used or disclosed to carry out treatment, payment and/or health care operations of Sinus and Nasal Specialists of Louisiana, LLC.
* This Authorization shall be in force and effect until records are received at which time this authorization to use or disclose this Protected Health Information expires.
* I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to 8585 Picardy Ave Suite 512 Baton Rouge, LA 70809. I understand that a revocation is not effective to the extent that Sinus and Nasal Specialists of Louisiana, LLC has relied on the use or disclosure of the Protected Health Information.
* I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
* Sinus and Nasal Specialists of Louisiana, LLC will not condition my treatment, payment, or enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide Authorization for the requested use or disclosure.
* I understand that I have the right to refuse to sign this Authorization.
* The information authorized for release may include records which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome ("AIDS") and/or mental health and/or substance abuse treatment.

🗷

Signature of Patient or Personal Representative Date