Stafford HealthCare Clinics
Established 1980
Walk In Clinic ◆ Occupational Medicine ◆ SEDA

CONSENT TO RELEASE MEDICAL INFORMATION

FORM101498

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM STAFFORD HEALTHCARE CLINICS

Patient's Name:_____

Date of Birth:_____

Phone Number:_____

I authorize STAFFORD HEALTHCARE CLINICS to release my medical records to:

_____
Name

_____
Address

_____
City, State, Zip

Or Fax #: _____

for the following purpose:_____

Specific Information To Be Released (including Dates)_____.

This authorization will expire 60 days from the indicated date below and it covers only treatment periods prior to that date. By signing this authorization, I allow Stafford HealthCare Clinics to furnish this information to the indicated party, even though the confidentiality of the information may be protected by Federal or State laws and regulations. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the authorization. The clinic is hereby released and discharged of any liability, and I will hold the clinic harmless for complying with this authorization. I acknowledge that I have a right to revoke this authorization by furnishing a signed and dated written statement of such desire to revoke the authorization to Stafford HealthCare Clinics. I acknowledge that Stafford HealthCare Clinics will not condition my treatment on whether I provide authorization for the requested use except if the health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. I understand that my request for these records will be filled within fifteen days and I agree to payment for these copies as stated in Louisiana Law.

_____ _____
Signature of Patient or Legal Representative / Relationship Date

_____
Witness

207 Westmark Blvd. • Lafayette LA 70506 • (337) 981- 6811 • (337) 981- 2024 Fax
www.staffordclinic.com