SCHLAMP MEDICAL CLINIC

921 1st Avenue • Sulphur, Louisiana 70663

337.527.6385 Phone • *337.527.3527* Fax • *1.833.682.7682* Text

www.Schlampmd.com

Authorization to Use and Disclose Specific Protected Health Information

I hereby authorize_____

To release information from the records of:
Patient_____ Date of birth_____

Information authorized to be released: (please check off item of request)

_____Medical Records Dates of service_____
_____ Insurance Information _____ Billing Records
_____ Demographic Information _____ Any and all
Other_____

Information may be released to:

Name_____
Address_____
City, State, Zip_____

Purpose of release:

____ Medical ____Personal
____Legal ____Insurance
Other _____

Understanding:

1. I understand that this consent may be revoked in writing at any time by directing such revocation to the requester of this authorization. I also understand that any disclosures made prior to the receipt of written revocation of this authorization are binding.
2. This authorization shall expire upon the expiration date of:_____
3. If I fail to specify an expiration date, or event, this authorization shall expire (6) six months from the date on which it was signed.
4. I understand that the 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 Law.
5. Release of this information by the provider will not result in remuneration to the provider by a third party.

Authorized Signature:

Signature_____ Date_____

Print name of person signing this form_____

Describe authority of other than patient_____