SOUTHERN VASCULAR CLINIC

INSERT PATIENT LABEL HERE

Authorization for Release of Medical Records

Patient Name:_____ Account Number: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Address: _____ Apt Number: _____

City: _____ State: _____ Zip Code: _____

Primary Contact Number: _____ Secondary: _____

I hereby authorize _____ to release information from my medical record to **DR. RACHEED J. GHANAMI** with **SOUTHERN VASCULAR CLINIC**.

Information to be released:

- History and Physical Exam
- Progress Notes
- Lab Reports
- Diagnostic Imaging
- Other: _____

I understand that this authorization will expire one year after I have signed the form. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal Privacy Regulations. By authorizing this release of information, my health care, and payment for my healthcare will not be affected if I do not sign this form. I understand I may see and copy this form after I sign it. I understand that in compliance with Title 40 of the Louisiana Administrative Code, Section 5123 Statute, I will pay a fee of $_____. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____

Signature of Patient/Legal Guardian Date