



Release of Information

I hereby authorize you to use or disclose the specific information described below, for the purposes and parties also described below.

Description of the specific information to be disclosed: **Medical Records**

Person or entity requesting the information and authorized to make the requested use or disclosure: _____

Recipient of the information: _____

This information is being requested for the following purpose(s).

This authorization shall remain in effect from the date signed below until _____ (expiration date or event). I understand that:

1. I may inspect or copy the protected health information to be used or disclosed.
2. I may revoke this authorization in writing by contacting your office at the following address: OSMS 301 Fourth St., Alexandria, LA 71301, Attention: Privacy Officer.
3. Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.
4. I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide the research-related treatment).

- If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name: _____

Patient Signature: _____

Relationship to Patient (if signed by personal representative of Patient) _____

Date: _____