David & Eldredge ENT Specialists, LLC
Lisa B. David & Brytton B. Eldredge
Authorization for Release of Medical Information

Patient's Name | Date of Birth | Social Security Number

Street Address | City | State | Zip

( ) Home Phone | ( ) Work Phone | ( ) Mobile Phone

The undersigned hereby authorizes and requests _____ to disclose the
(Name of Dr. /entity who the patient wants records sent from)
following Protected Health Information to David & Eldredge ENT Specialists, LLC

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 David & Eldredge ENT Specialists, 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 *Angel Heinen at 109 Rue Fontaine, Lafayette, LA 70508.* I understand that a revocation is not effective to the extent that David & Eldredge ENT Specialists, 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.
- David & Eldredge ENT Specialists, 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

Please **PRINT** the name **and/or** Description of Patient **or** Personal Representative | Date