MEDICAL RECORDS USE ONLY:

Amount Due: ____________________
Released By: ____________________
Date Released: __________________

ACADIAN MEDICAL CENTER
3501 HWY 190 EAST
EUNICE, LA 70535

REQUEST/RELEASE OF MEDICAL INFORMATION

This consent authorizes ____________________________________to release the following information on:

Patient Name **Individual/Facility Receiving Information**

Purpose of Release:	__ Insurance	
	__ Continued Care	
	__ Disability	
	__ Other:	

According to LSA-R.S. 40:1299.96(A) (2) (b) the health care provider may charge a reasonable charge to have information copied. The first twenty-five (25) pages are provided to you as a courtesy. Charges will be $0.15 per page thereafter.

Specific Condition and/or Dates to be Disclosed:		**List Account Number if available:**

__ I authorize the release of information concerning drug-related conditions, alcoholism, psychological conditions, and/or infectious disease including but not limited to blood-borne disease.

Information To Be Released:	__ Entire Record		__ Face Sheet and/or DRG Sheet
__ History and Physical	__ Discharge Summary		__ Progress Note(s)
__ Consult and/or Operative Report	__ LAB (includes Reference)		__ Radiology Report
__ Respiratory (includes EKG)	__ Other (Specify)		

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon, and, if not revoked sooner in writing, the consent will expire in 6 months from the (DAY SIGNED) or (DATE OF DISCHARGE).

I understand that the persons hereby authorized to use/disclose information will not condition treatment or payment on my providing this authorization.
I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.

To the receiving party of this information – This information has been disclosed to you for the sole purpose stated in the consent. Any other use of this information without the expressed written consent of the patient is prohibited. These records may be protected by FEDERAL REGULATION (42 CR, Part 2).

Printed Name of Patient or Authorized Individual		Relationship of Authorized Individual if not Patient
Signature of Patient or Authorized Individual		Date

If verbal authorization obtained:

Printed Name of Witness		Signature of Witness	
		Date:	
Printed Name of Witness		Signature of Witness	
		Date:	

MEDICAL RECORDS USE ONLY:

Amount Due: ____________________
Released By: ____________________
Date Released: _________________

ACADIAN MEDICAL CENTER
3501 HWY 190 EAST
EUNICE, LA 70535

REQUEST/RELEASE OF MEDICAL INFORMATION

This consent authorizes ___________________________________to release the following information on:

Patient Name **Individual/Facility Receiving Information**

Purpose of Release:	__ Insurance	
	__ Continued Care	
	__ Disability	
	__ Other:	

According to LSA-R.S. 40:1299.96(A) (2) (b) the health care provider may charge a reasonable charge to have information copied. The first twenty-five (25) pages are provided to you as a courtesy. Charges will be $0.15 per page thereafter.

Specific Condition and/or Dates to be Disclosed:		**List Account Number if available:**

__ I authorize the release of information concerning drug-related conditions, alcoholism, psychological conditions, and/or infectious disease including but not limited to blood-borne disease.

Information To Be Released:	__ Entire Record		__ Face Sheet and/or DRG Sheet
__ History and Physical	__ Discharge Summary		__ Progress Note(s)
__ Consult and/or Operative Report	__ LAB (includes Reference)		__ Radiology Report
__ Respiratory (includes EKG)	__ Other (Specify)		

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon, and, if not revoked sooner in writing, the consent will expire in 6 months from the (DAY SIGNED) or (DATE OF DISCHARGE).

I understand that the persons hereby authorized to use/disclose information will not condition treatment or payment on my providing this authorization.
I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.

To the receiving party of this information – This information has been disclosed to you for the sole purpose stated in the consent. Any other use of this information without the expressed written consent of the patient is prohibited. These records may be protected by FEDERAL REGULATION (42 CR, Part 2).

Printed Name of Patient or Authorized Individual		Relationship of Authorized Individual if not Patient
Signature of Patient or Authorized Individual		Date

If verbal authorization obtained:

Printed Name of Witness		Signature of Witness	
		Date:	
Printed Name of Witness		Signature of Witness	
		Date:	