AUTHORIZATON FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:

Patient's Date Birth:

Patient's SSN:

I authorize the release of my medical records from the following listed.

DR._____

_____

Address City State Zip

To forward a copy of the following medical records.

__ Complete Medical Records
__ Lab Reports
__ Operative Reports / Notes
__ Medication List
__ Radiology Reports

For the dates of service _____

To: Dr. Dung Michael Tran Dr. Alex Hoang Dr. Charlie Le (circle one)
3848 Veterans Memorial Blvd., Suite 101
Metairie, La 70002
Phone (504) 885-2505 Fax (504) 885-2510

1. I understand that this authorization will expire on _____.
2. I understand that I may revoke this authorization (except to the action was already taken in reliance on this signed authorization).
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits.
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information describe above may be redisclosed and would no longer be protected by these regulations.

_____

Signature of Patient / Representative Date