

Louisiana Allergy Asthma Specialists

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*Allergy, Asthma, and
Clinical Immunology*

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Authorization to Release or Obtain Health Information (including paper, oral, and electronic information)	
Name:	Request Date:
Mailing Address:	Date of Birth:
City / State / Zip:	Social Security #:
<p>I authorize:</p> <p>Name: <u>Benjamin B. Close, M.D. Rebecca Brady, NP. David Mickey, M.D.</u></p> <p>Mailing Address: <u>201 Pecan Park Avenue</u></p> <p>City, State, Zip Code: <u>Alexandria, LA 71303</u></p> <p>Telephone Number: <u>318-445-6221</u> Fax Number: <u>318-445-5399</u></p> <p style="text-align: center;"><input type="checkbox"/> RELEASE information TO or <input type="checkbox"/> OBTAIN information FROM <i>(Place an "X" in the box that indicates if the information is being released or requested.)</i></p> <p>Name: _____</p> <p>Mailing Address: _____</p> <p>City, State, Zip Code: _____</p> <p>Relationship: _____ Telephone Number: _____</p>	
<p>The Purpose of this Authorization is indicated in the box(es) below. <i>(Place an "X" in the box(es) that apply.)</i></p> <p><input type="checkbox"/> Further Medical Care <input type="checkbox"/> Personal <input type="checkbox"/> Legal Investigation or Action</p> <p><input type="checkbox"/> Changing Physicians <input type="checkbox"/> Research related treatment</p> <p><input type="checkbox"/> Creating health information for disclosure to a third party</p> <p><input type="checkbox"/> Other: (Specify) _____</p>	
<p>I authorize the release of the following protected health information. <i>(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)</i></p> <p><input type="checkbox"/> Entire Record <input type="checkbox"/> Medical History, Examination, Reports <input type="checkbox"/> Surgical Reports <input type="checkbox"/> Treatment or Tests</p> <p><input type="checkbox"/> Prescriptions <input type="checkbox"/> Immunizations <input type="checkbox"/> Hospital Records including Reports <input type="checkbox"/> Laboratory Reports</p> <p><input type="checkbox"/> X-ray Reports <input type="checkbox"/> Other: _____</p>	
<p>In compliance with state and / or federal laws which require special permission to release otherwise privileged information, please release the following records.</p> <p><input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Mental Health <input type="checkbox"/> Vocational Rehabilitation <input type="checkbox"/> HIV (AIDS)</p> <p><input type="checkbox"/> Sexually Transmitted Diseases <input type="checkbox"/> Genetics <input type="checkbox"/> Psychotherapy Notes</p> <p><input type="checkbox"/> Other: _____</p>	
<p>This authorization shall expire on _____ (date or event.)</p> <p>I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed.</p>	
<p>_____ Signature of Individual or Personal Representative authorized by law</p> <p style="text-align: right;">_____ Date</p>	

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