Louisiana Allergy
Asthma Specialists

Benjamin B. Close, M.D.,
FACP, FAAAAI, FACAAI

Allergy, Asthma, and Clinical Immunology

Carol Netherland, *MSN, CFNP, AE-C*
Nurse Practitioner
Certified Asthma Educator

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 #:

I authorize:

Name: Benjamin B. Close, M.D. Carol A. Netherland, MSN, CFNP

Mailing Address: 201 Pecan Park Avenue

City, State, Zip Code: Alexandria, LA 71303

Telephone Number: 318-445-6221 Fax Number: 318-445-5399

☐ **RELEASE Information TO** or ☐ **OBTAIN Information FROM**
(Place an "X" in the box that indicates if the information is being released or requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action

☐ Changing Physicians ☐ Research related treatment

☐ Creating health information for disclosure to a third party

☐ Other: (Specify) _____

I authorize the release of the following protected health information.
(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Treatment or Tests

☐ Prescriptions ☐ Immunizations ☐ Hospital Records including Reports ☐ Laboratory Reports

☐ X-ray Reports ☐ Other: _____

In compliance with state and / or federal laws which require special permission to release otherwise privileged information, please release the following records.

☐ Alcoholism ☐ Drug Abuse ☐ Mental Health ☐ Vocational Rehabilitation ☐ HIV (AIDS)

☐ Sexually Transmitted Diseases ☐ Genetics ☐ Psychotherapy Notes
☐ Other _____

This authorization shall expire on _____ **(date or event.)**

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.

_____ _____
Signature of Individual or Personal Representative authorized by law Date

201 Pecan Park Avenue
Alexandria, LA 71303

Phone (318) 445-6221
Fax (318) 445-5399