AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize _____ (covered entity) to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Medical Rehab of Kenner
3227 Williams Blvd.
Kenner, LA 70065

Phone: (504) 305-6565
Fax: (504) 305-6622
Email: drpace@drkenpace.com

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Social Security Number: _____

Patient's Address: _____

_____

Disclose the following PHI for treatment dates _____ to _____

[ ] Abstract/Pertinent [ ] History & Physical [ ] Discharge Summary [ ] Consult

[ ] Operative Report [ ] Progress Notes [ ] Physician Orders [ ] Nurse's Notes

[ ] ER Report [ ] Lab [ ] X-ray [ ] Entire Chart

[ ] Other Specified: _____

The above information is disclosed for the following purposes:

[x] Medical Care [ ] Legal [ ] Insurance [ ] Personal [ ] Other _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV or genetic information. _____ (Initial)

This authorization shall expire upon this expiration date: _____
If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Medical Rehab of Kenner. I understand that the revocation will not apply to information that has already been released to this authorization. I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected information stated.

_____ _____
Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature Witness Date