# Authorization to Release Health Information/Medical Records

## I. Release Authorized For/By:

Patient Full Name: _____

Previous Name(s): _____

Patient Address: _____

Patient DOB: _____

## II. Requested From the Following Healthcare Providers or Facilities:

| Name | Provider Address | Provider Phone/Fax |
|---|---|---|
| | | |
| | | |
| | | |

## III. Records to be Released:

Please release the following records:

- ▫ All patient records pertaining to all conditions (Complete Record)
- ▫ Medical records for dates of service from: _____to_____.
- ▫ Only records pertaining to these diseases or conditions:

  _____
- ▫ Include behavioral health notes. (Must check here in addition to other boxes)
- ▫ Include HIV/STD results. (Must check here in addition to other boxes.)
- ▫ Please EXCLUDE the following records:

  _____

## IV. To be Released to:

**DIABETES CARE CENTER**
**Attn: Medical Records**
**823 West California Ave**
**Ruston, La 71270**
**(318)224-3044 Phone**
**(318)232-2978 FAX**

**By signing below, I authorize the healthcare providers or facilities listed in Section II above to release the medical records and health information, as described in Section III, to the Diabetes Care Center. This authorization is valid until _____ or for 30 days whichever is of shorter duration. I may revoke this authorization prior to the actual release of the information.**

_____ _____

**Patient/Parent/Guardian Signature** **Date**