Ark-La-Tex Spine, APMC
8660 Fern Ave, Suite 120
Shreveport, LA 71105-6810

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

_______________________________ _______________________________
Print Name of Patient Previous Name (If Applicable)

_______________________________ _______________________________
Date of Birth Daytime Telephone Number

INFORMATION TO BE RELEASED FROM:

Provider Name: _______________________________
Address: _______________________________
____
Phone: _______________ Fax: _______________

SEND INFORMATION TO:

Provider Name: Ark-La-Tex Spine Care, Dr Jeff Adair
Address: 8660 Fern Ave, STE 120 Shreveport, LA 71105
Phone: 318-841-9999 Fax: **318-841-9996**

INFORMATION TO BE DISCLOSED:

- ☐ Medical Records from last two years
- ☐ Summary Health Information
- ☐ Complete Designated Record Set
- ☐ Other _______________ Expiration Date _______________

If the patient is unable to sign, please indicate such and authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPPA act of 1996.

__________ _______________________________ _______________________________
Date Signature of patient or representative Relationship to patient

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

- ☐ HIV/ AIDS Virus
- ☐ Mental Health/ Psychiatric Disorders
- ☐ Sexually Transmitted Diseases
- ☐ Drug & Alcohol Abuse/ Treatment

__________ _______________________________ _______________________________
Date Signature of patient or representative Relationship to patient