Office Phone : (504) 455-4999
Fax Number: (504) 455-9031

Jefferson Headache and Spine,LLC

Patient Information

Name: _____ Date of Birth: _____

Social Security# (Last 4):_____ Telephone #:_____

Release Information From:

I hereby authorize ☐ Jefferson Headache and Spine or ☐ _____

Tel: _____ Fax: _____

Release Information To:

Name: _____

Street Address: _____

Tel: _____ Fax:_____

Information To Be Released:

☐ **All Medical Records** **or** ☐ **Dates of Treatment: _____**

☐ **Other** **Dates of Treatment:_____**

I understand that my health information may be protected by federal privacy laws, I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facilities receiving it, and would then no longer be protected by federal privacy regulations.

I understand this authorization covers records related to communicable diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such records exist.

I understand that I may revoke this authorization at any time except to the extent that Jefferson Headache and Spine has already taken action in reliance upon it. I understand that in order to revoke this authorization, I must do so in writing and present my written notice to Jefferson Headache and Spine. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Unless otherwise revoked, this authorization expires one year from the date of signature, A photocopy or scanned signature shall have the same force and effect as the original.

Signature of Patient: _____ Date:_____