martha e.stewart,md,llc
dermatology

martha e. stewart, md
olivia a. gioe, md
*board certified dermatologists*

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
(Last, First)

I hereby request and authorize:
_____
_____

To release my protected health information to:

**__ Martha E. Stewart, MD**

**__ Olivia A. Gioe, MD**

**4060 Lonesome Rd**
**Mandeville, LA 70448**
**P) 985-727-7701**
**F) 985-727-7375**

Purpose of this disclosure: _____

Information to be disclosed (check all that apply): Start Date End Date

_ All Medical Records ….....
_ Progress Notes ….....
_ Laboratory Test ….....
_ X-Ray Tests/ Reports ….....
_ History and Physical Examination ….....
_ Discharge Summary ….....
_ Consultation Reports ….....
_ Other:

**The following information will be released when included in the above information unless you indicate otherwise:** AIDS or HIV test results, Alcohol, drug or substance abuse treatment, Psychiatric or mental care treatment, and/or other (please specify):

**I understand that:**

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment, or enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke the authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal policy regulations and may be disclosed.
5. A photographic or faxed copy of this authorization shall be valid as the original.
6. This consent shall remain in effect until six months from date of signature.

Signature of Patient: _____ Date: _____
Signature of Representative, if patient is a minor: _____ Date: _____
Relationship of Representative to patient: _____