Frederick Rau MD · David Rau MD · Eric Rau MD · Donald Schwab Jr MD

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION (PHI)

Patient Name	Request Date
Address	Date of Birth
City, State, Zip	SSN

I AUTHORIZE:

Bayou Surgical Specialists, LLC
5619 Hwy 311 Ste A Houma, LA 70360 / Phone: 985-868-2273 Fax: 985-851-4898

☐ TO RELEASE INFORMATION TO or ☐ TO OBTAIN INFORMATION FROM

(Mark the box that indicates if the information is being released or requested)

Name		
Address	Phone	
City, State, Zip	Fax	
Purpose of this disclosure:	O Further Medical Care	O Personal
	O Legal	O Other _____
Authorization expiration date or event: (If not indicated, authorization will expire 12 months from date signed)		

Health information to be released under this authorization:			
Service Dates:	O Medical Notes/Summary	O History & Physical	O Pathology
O Operative/Procedure Reports	O X-Rays, EKG	O Recent Labs	O All Medical Records
O Other: *(please specify)*			

The following information will be released when included in the above **unless you indicate otherwise**. Do not release:	
O AIDS or HIV test results	O Mental health or psychiatric care
O Alcohol/substance abuse treatment	O Other: *(please specify)*

- I hereby authorize the use and disclosure of my individually identifiable health information as described above.
- I understand that if the person or entity receiving this information is not a health plan or health care provider covered by federal privacy regulation, the released information may not be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying Bayou Surgical Specialists in writing. However, if I choose to do so, I understand that my revocation will not affect any information that was released prior to my revocation.
- I understand that this authorization is voluntary and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
- I have a right to receive a copy of this form after I sign it.

Signature of Patient:	Date:
Signature of Authorized Representative (if necessary):	
Authorized Representative's Relationship to Patient:	