



Lafayette Heart and Vascular Clinic

433 La Neuville Rd, Youngsville, LA 70592 | Phone: (337) 516-2800 | Fax: (337) 516-2801 | Email: patient@lafayetteheart.com

Authorization for Release of Medical Records (Send Records FROM Lafayette Heart and Vascular Clinic)

Patient Information

Name: _____

DOB: _____ Last 4 SSN: _____ Phone: _____

Release Records To

Name/Organization: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ ZIP: _____

Records Requested

Complete Medical Record **OR** Specific Records (check all that apply):

Office Notes Lab Results EKG Reports Echocardiogram Reports Imaging Reports Other: _____

Date Range: _____ to _____ Other: _____

Format: Paper (mailed) Digital/CD Fax Purpose: Medical Care Personal Insurance Legal Other: _____

Patient Acknowledgment: I understand that:

- (1) I may revoke this authorization in writing at any time;
- (2) Information released may be re-disclosed by recipient and no longer protected by HIPAA;
- (3) Fees may apply per clinic policy and will be invoiced before release;
- (4) Treatment is not conditioned on signing this authorization;
- (5) This authorization expires one year from date of signature or on ___/___/___ (if earlier date specified).

Patient/Rep Signature: _____ Date: _____

Print Name: _____ If Representative: Parent/Guardian POA Legal Rep Other: _____

FOR OFFICE USE ONLY:

Received: ___/___/___ By: _____ Eligibility: Confirmed Pending

Fee: \$_____ Invoiced: ___/___/___ Paid: ___/___/___ Released: ___/___/___ Method: Fax Mail Digital

NOTICE TO RECIPIENT: This information is protected by federal/state confidentiality rules (42 CFR Part 2, HIPAA). Further disclosure prohibited without written consent or as permitted by law.