



First Choice Surgery Center, LLC

Arnold E. Feldman, M.D.
Medical Director

**Authorization to Release or Obtain Health Information
(including paper, oral and electronic information)**

Name: _____ Request Date: _____

Mailing Address: _____ Date of Birth: _____

_____ Social Security#: _____

I AUTHORIZE:

Dr. Arnold E. Feldman, and/or The Feldman InstituteSM, and/or First Choice Surgery Center of Baton Rouge, LLC, located at 505 E. Airport Drive and 455 E. Airport Drive, respectively, Baton Rouge, Louisiana 70806, as a physician or practice, under whose care I am under or under whose care I am seeking, to:

RELEASE information TO **OR** **TO OBTAIN information FROM**
(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Tel #: _____ Fax #: _____

The **Purpose of this Authorization** is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)

- Further Medical Care Personal Legal Investigation or Action
- Changing Physicians Research related treatment
- Getting health information for disclosure to a third party.

Other (Specify): _____

I authorize the release of the following protected health information:

(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

- Entire Record Medical History, Exams, Reports Surgical Reports
- Treatment or tests Prescriptions Immunizations MR/DD Records
- Hospital Records Lab Reports Diagnostic Reports (X-Ray, CT, etc..)
- Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records:

- Alcoholism Drug Abuse Mental Health Genetics
- Vocational Rehab HIV (AIDS) Sexually Transmitted Diseases
- Psychotherapy Notes Other: _____

This authorization shall expire on _____ (date/event)

and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both this form and the Notice of Privacy Practices of the provider(s).

Signature of Individual or Authorized Representative

Date

Signature of Witness (*If signed with an "X" or mark*)

Date