**Willis−Knighton Health System**
2600 Greenwood Road
Shreveport, LA 71103

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Printed Name of Patient _____ Previous Names, if applicable _____

Date of Birth _____ Daytime Telephone Number _____

**SEND INFORMATION TO: (please be specific)**
Provider Name/Organization: Willis Knighton Endocrine Specialists
Address: 2449 Hospital Drive, Suite 400
Bossier City, Louisiana 71112
Phone #: 318-212-7902 Fax #: 318-212-7905

**INFORMATION TO BE RELEASED FROM: (please be specific)**
Provider Name/Organization: _____
Address: _____

Phone #: _____ Fax #: _____

**PURPOSE OF DISCLOSURE:** ☐ Transfer of Care ☐ Self ☐ Specialist ☐ Other _____ (must complete)

**INFORMATION TO BE DISCLOSED:**
☐ Medical Records from last two years
☐ Summary Health Information
☐ Complete Designated Record Set
☐ Other: _____

Dates of Service: _____

**Expiration Date (or event)** _____

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re−disclosure and may no longer be protected by HIPAA of 1996. I acknowledge that I have received a copy of the Notice of Privacy practices. _____ (Initials)

Date _____ Signature of Patient or Representative _____ Relationship to Patient _____

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

☐ HIV/AIDS Virus _____ ☐ Mental Health/Psychiatric Disorders _____
☐ Sexually Transmitted Diseases _____ ☐ Drug, Alcohol Abuse/Treatment _____

Date _____ Signature of Patient or Representative _____ Relationship to Patient _____

For Facility Use:
Date Received: _____ Date Information Released: _____ Chart #: _____
Person /Department Sending Records: _____