



Willis-Knighton Health System
 2600 Greenwood Road
 Shreveport, LA 71103

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

X
 Printed Name of Patient _____
X
 Date of Birth _____

Previous Names, if applicable _____
 Daytime Telephone Number _____

SEND INFORMATION TO: (please be specific)

Provider Name/Organization: WKB Family Medicine Associates
 Address: 2449 Hospital Drive, Suite 420
Bossier City, LA 71111
 Phone #: (318) 212-7839 Fax #: (318) 212-7837

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 X 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 _____
- Sexually Transmitted Diseases _____
- Mental Health/Psychiatric Disorders _____
- Drug, Alcohol Abuse/Treatment _____

 Date X Signature of Patient or Representative Relationship to Patient _____

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