Patient Name:_____
Date of Birth:_____
Phone Number: _____

John Brantley, MD and Gloria Marchand APRN
Tele: (225) 766-5151 Website: calaisdermatology.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize and request_____ to release the following protected health information from the medical records of the patients listed above to: _____.

- To be mailed/faxed to: _____.
- By electronic access to medical and claims information
- Through oral communication with healthcare providers regarding treatment, care or payment.

The specific information for the following dates of service: _____.

INFORMATION TO BE DISCLOSED:

- Entire Record
- Laboratory Reports
- Operative Reports
- History and Physical (e.g., Doctor Visit)
- Other: _____.

Expiration date of this authorization: _____.

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy laws. To the extent that this form authorizes the sale of your Protected Health Information, such as a disclosure will result in remuneration to the practice. By signing this form, you authorize Calais Dermatology Associates to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Signature of Witness