AUTHORIZATION FOR THE USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

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As required by the Health Information Portability and Accountability Act of 1996, Drs. Louapre, Kokemor & Sarrat, L.L.C. may not use or disclose your health information except as provided in our Notice Of Privacy Practice without your authorization. Your signature on this form indicates that you are giving permission for the release of medical information as described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, _____ (print name) hereby authorize the use/disclosure of the following health information that pertains to me

____ Discharge Summary
____ History & Physical
____ Progress Notes
____ ER Records
____ Lab Reports
____ Pathology Reports
___ X Ray Reports
___ X-ray Films
___ Alcohol and/or drug abuse information (see below)
___ HIV –related information (see below)
___ Psychiatric related information
___ Operative Reports
___ Other: Specify_____

for the following purpose(s):

____ Review of my past medical conditions
____ To assist in the continuation of my medical care

I authorize the following person/persons to receive these disclosures of my health information:

_____ _____
Name Relationship:

I authorize the following person/persons to make these disclosures of my heath information:

___ Rene A. Louapre, III,M.D. ___ John J. Kokemor, M.D. ____ Stephanie L. Sarrat, M.D.
___ Gary B. Braedt, M.D.

and/or authorized representative of Drs. Louapre, Kokemor & Sarrat, L.L.C.

Other: _____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Drs. Louapre, Kokemor & Sarrat, L.L.C. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclosed my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire ____/____/____.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

_____ _____

Signature Date

REVOCATION SECTION

I hereby revoke this authorization.

_____ _____

Signature Date