FAMILY CONVENIENCE CLINIC

2933 Cypress Street
West Monroe, LA 71291
Ph: (318) 322-9252
Fax: (318) 322-2885

PATIENT NAME: _____

PATIENT DOB: _____

DATE: _____

PATIENT ADDRESS: _____

CITY / STATE / ZIP: _____

I. **My Authorization:** (*to release protected health information*)

Family Convenience Clinic may use or disclose the following health care information (check all that apply):

- ☐ All my health information maintained by the above-named practice
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information for the date(s): _____
- ☐ Other: _____

Family Convenience Clinic may disclose this protected health information to:

_____

Provider Name and Credentials or Health Care Entity

_____

Mailing Address City State Zip

II. **My Authorization:** (*to receive protected health information*)

I authorize the following: _____

Provider Name and Credentials or Health Care Entity

To release to Family Convenience Clinic the following protected health information:

- ☐ All my health information maintained by the above-named practice
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information for the date(s):_____
- ☐ Other: _____

This authorization is effective through _____ / _____ / _____ or the following event: _____ unless revoked or terminated by the patient or the patient's representative before the date listed above.

II. **My Rights:**

I understand I do not have to sign the authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing . If I did, it would not affect any actions already taken by the above-named practice based upon this authorization, I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Complete a Revocation Form, or
- Write a letter to the office.

Once Family Convenience Clinic discloses health information, the person or covered entity that receives it may re-disclose it; therefore, privacy laws may no longer protect it.

_____ _____ _____

Patient or legally authorized individual signature Relationship Date