Dr. N. Knight Worley | Dr. Jacqueline Magne

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Telephone: (504) 899-1513 Fax: (504) 897-8637

Patient name _____ (print name)

Date of birth _____ Relationship (if minor) _____

I authorize _____ and the physicians who treated me to release medical records to: _____

Telephone # _____ Fax # _____

Address _____

Requested records:

- ☐ All records
- ☐ Clinical/consultation notes; date range: _____
- ☐ Test results; specifically: _____
- ☐ Operative/pathology results; specifically: _____
- ☐ Disc with images; specifically: _____

- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.
- I understand that I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed unless otherwise noted below. Revocation of this release must be made in writing.
- A photocopy or fax of this authorization is as valid as the original.
- Any and all records are confidential and cannot be disclosed without prior written authorization, except as otherwise provided by law.
- Requests are processed within 7-10 business days of receiving requests.
- Fees/charges will comply with all laws and regulations applicable to Protected Health Information (PHI): $1.00/page for up to 25 pages, $0.50/page for 26-350 pages, $0.25/page for 351+ pages, as well as postage and processing. Fees/charges must be paid prior to the release of records.

Signed _____ Date _____

Expiration Date (if different than one year) _____

If patient is a minor, parent/guardian signature:

Signed _____ Date _____