AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name:_________________________________ DOB:______________ SSN:_________________

INFORMATION TO BE RELEASED FROM:

Name of Facility/Provider:____

Address:____________________________Phone:__________________Fax:______________

INFORMATION TO BE SENT TO:

Name of designated recipient: The Healing Clinics, LLC Phone:318-227-4088

Address: 745 Olive Street Ste. 202 Shreveport,LA 71104 Fax:318-227-4086

INFORMATION TO BE RELEASED: (CHECK ONE)

☐ Most recent office visit progress notes (last 3-5 visits) signed by a physician confirming your debilitating qualifying condition of:

____

☐ Coordination of Care

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: TO DETERMINE THE PATIENTS QUALIFYING CONDITION TO BE TREATED WITH THERAPEUTIC MARJIUANA.

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released, unless otherwise indicated:

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MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may redisclose it, at which time it may no longer protected under Privacy Laws.

Signature:______________________________________ Date:__________________
(parent, guardian, or authorized person)

THIS AUTHORIZATION WILL EXPIRE THIRTY (30) DAYS AFTER DISCHARGE
(UNLESS OTHERWISE INDICATED)