Authorization for Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Kevin M. Plaisance M.D., L.L.C., to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of Kevin M. Plaisance M.D., L.L.C.

Name and relationship of person you wish to allow access~for example: your spouse, child, sibling, neighbor, caretaker, clergy, or close friend.

Name of Person or Entity	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and in effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Kevin M. Plaisance M.D., L.L.C. and may no longer be protected by federal law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Kevin M. Plaisance M.D., L.L.C... I understand that the revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Signature of Patient or Personal Representative Date

Print Name of Patient or Personal Representative and Relationship to Patient

Witness Date

200 Greenbriar Blvd, Covington, LA 70433 (985)893-3777office (985)893-8030fax