Aimee D. Guidry, ANP-C

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Henderson, LA 70517

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**COMMUNITY HEALTHCARE CLINIC**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release copies of medical records and other information concerning my diagnosis and treatment, including but not limited to information concerning treatment of drugs and alcohol abuse, alcoholism, drug related conditions, HIV testing or treatment of HIV related conditions, psychiatric/physiological conditions. Review of records is also authorized.

The following information may be released or reviewed:

\_\_\_\_\_ History and physical exam

\_\_\_\_\_ Laboratory Studies

\_\_\_\_\_ X-ray reports and other Testing

\_\_\_\_\_ Consultation

\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The above information is to be released to:*

*COMMUNITY HEALTHCARE CLINIC*

*1421 HENDERSON HWY*

*HENDERSON, LA 70517*

Purpose for Disclosure:

*CONTINUITY OF CARE*

Redisclosure is prohibited without specific consent of the person to whom it pertains.

This statement must be signed and dated and may be revoked at any time to the extent action had been taken prior to revocation. This consent will expire 60 (sixty) days after the date below, or sooner by choice, in which case this consent will expire on \_\_\_\_\_\_\_\_.

|  |  |
| --- | --- |
| Patient Name: | Patient Signature: |
| Address: | Person legally authorized for consent: |
| Date of Birth: | Relationship to Patient: |
| Witness: | DATE: |