LAGNIAPPE MEDICAL CENTER

Authorization to Receive Medical Records Information

Patient's Name (First, Middle, Last):				Date of Birth (mm/dd/yyyy):	
Address:				City:	
State		Zip:			
Last 4 of SSN#		Home Phone		Cell Phone	
		Contact Preference	☐		☐

I authorize the release of my medical records by the organization or physician listed below:

Physician Name		Phone Number	
Physician Phone		Fax Number	
Reason for Release			

These records are being sent to Lagniappe Medical Center at the fax or email below. The type and amount of information to be disclosed is initialed as follows:

☐ Entire Medical Record
☐ X-ray films
☐ Immunizations
☐ Genetic testing, from date
☐ Psychological or psychiatric conditions, if any
☐ Labs and Test results
☐ Substance and Drug Abuse, if any
☐ Most recent 5 years of records

Specific dates or procedures:

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, or the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

Patient's name (print):	
Patient's signature:	
Today's Date:	

Lagniappe Medical Centers
Medical Records
Phone (803) 419-7780, Option 2
Fax (855) 324-8313
Email: medrec@lagniappemedicalclinic.com