NORTHSHORE
FAMILY MEDICAL CENTER

1150 Robert Blvd. Suite 100 Slidell, LA 70458 985-646-1122 Fax 888-865-7591

Authorization for Release of Protected Health Information from Northshore Family Medical Center

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I understand that my health care will not be affected if I do not sign this form. I understand that I may revoke this request in writing. I understand there may be a charge associated with this request.

Patient Name	Date of Birth
Street Address	City, State and Zip
Organization Providing the information Northshore Family Medical Center 1150 Robert Blvd. Suite 100 Slidell, LA 70458 985-646-1122 Fax 888-865-7591	Person or organization receiving the information
Specific description of information ___Entire Chart __Specific Visit Date_____ ___Other (please specify)_____	___Radiology Reports ___Labs ___Exclude drug, alcohol or psychiatric information
What is the purpose of the use or disclosure?	I understand this authorization expires on_____ Or in 6 months, whichever occurs first.
Signature	Todayõs Date
NSFMC office staff use: Date completed_____ # of pages _____	___Mailed ___Faxed ___Hand Delivered