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

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.

Patient Name	Date of Birth
Street Address	City, State and Zip
Organization Providing the information Provider Name: Name of Clinic: Phone: Fax #:_____	Person or organization receiving the information Northshore Family Medical Center 1150 Robert Blvd. Suite 100 Slidell, LA 70458 985-646-1122 Fax 888-865-7591

Specific description of information

☐ ***** Please send ONLY information from the last 2 years.**
(Preferred- unless deemed medically necessary.)

☐ Other (please specify)_____

☐ 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	Todayôs Date
NSFMC office staff use: Date request was faxed_____ Records received_____	