Pointe Coupee General Hospital
2202 False River Drive
New Roads, Louisiana 70760
Health Information Phone: (225) 638-5771
Health Information Fax: (225) 618-4509

Release of Patient Information Consent Form

* Required

Identifying Information

Patient's Name *: _____ Phone Number *: _____

Physician: _____

Date of Birth *: _____ Medical Record #: _____

Date of Treatment: _____

Release To

Name *: _____

Address: _____

Reason: _____

Information to be Released *

☐ Emergency Room ☐ X-Ray ☐ Laboratory ☐ EKG ☐ Transcription

☐ Other: _____

Please Initial *

____ I hereby authorize **Pointe Coupee General Hospital** to furnish the above-named individual or company with all medical data and information they may request, as listed above, concerning my illness or injury. *

____ This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate **1 year** from the date of consent without express revocation. *

____ I hereby consent to the release of any and all records containing **alcohol and/or drug abuse and/or psychiatric diagnosis, sexually transmitted diseases, acquired immunodeficiency syndrome, or human immunodeficiency virus** under the same consideration as outlined above. I understand that such information cannot be released without my specific consent, except in accordance with a court order. *

____ I further understand that I have a right to receive a copy of this authorization upon request. *

Signed

_____ _____
Patient, Parent/Legal Guardian * Date *

_____
Address City State Zip Code

_____ _____
Witness Title