Preferred Health & Wellness
1011 Verret St
Houma, LA 70360
Craig Wade, MD
Lacee Cavalier, FNP
Phone: (985) 293-2300
Fax: (985) 293-2301

Authorization to Disclose Protected Health Information

Patient Name: _____ **DOB:** _____

I hereby authorize _____ to disclose the following Protected Health Information from the medical record of the patient listed above to:

_____

_____

Disclose the following PHI for treatment dates: _____ to _____

Office notes
Lab Reports
Radiology Reports/Diagnostic Reports
Cardiology Reports
Other: _____

The following information is disclosed for the following purpose:
Medical Care
Other: _____

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Preferred Health & Wellness. I further understand that any such revocation does not apply to the extent that persons authorized use or disclose my health information have already acted in reliance on this authorization.

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

This authorization will expire 6 months from the date on which it was signed unless otherwise noted.
Expiration Date:

I have read the above and authorize the disclosure of the Protected Health Information as stated.

_____ Date: _____

Signature of Patient