



# ENT & PLASTIC SURGERY Specialists of Louisiana

## MEDICAL RECORDS REQUEST REQUEST FOR PROTECTED HEALTH INFORMATION (PHI)

**Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

This request will expire on the following date \_\_\_\_\_ or in the event of \_\_\_\_\_.  
If date or event is not indicated, authorization will expire on January 1st the next calendar year.

**I hereby request a copy of the sections of my medical record as indicated below to be forwarded to ENT & Plastic Surgery Specialists of Louisiana at fax number 985-867-5498.**

- History and Physical Exam and Progress Notes
- Audiology: Hearing Test / Balance Study / ABR / Etc.
- Consultation Reports
- Hospital Operative / Discharge Summary
- Lab / Pathology Results
- Radiology Reports: CT / MRI / X-Ray / Ultrasound / Etc.
- Sleep Study Results / Compliance Downloads
- Other

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*Patient or Legal Guardian*

**Please include this request as a coversheet when returning records.**

**Faxed To:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**From:** \_\_\_\_\_ **Phone Number:** 985-845-2677 **Ext:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*Practice Representative*

**Warning:** This message is intended only for the person listed above. The attached information is confidential and considered privileged by law. If the reader of this fax is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you are not the intended recipient, please notify us and shred this information. Thank you for your cooperation.