ENT & PLASTIC SURGERY
Specialists of Louisiana

RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient: _____ **Date of Birth:** _____

I authorize **Kevin E. McLaughlin, MD, APMC** to release my protected health information (PHI) including medical records, appointments, and financial information to the person(s) listed blow:

Please provide name, relationship, and telephone number for each person to whom you are authorizing release of your private health care information.

Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

☐ My protected health information (PHI) shall **NOT** be release to anyone.

This authorization shall be in force and effect until I notify Kevin E. McLaughlin, MD, APMC in writing to revoke this authorization. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Office at 350 Lakeview Court, Suite A, Covington, LA 70433. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the physician from a third party.

Signature: _____ **Date:** _____
Patient or Legal Guardian