



James E. Smith, M.D., F.A.C.C.  
Umesh A. Patel, M.D., F.A.C.C.  
Ali M. Amkieh, M.D., F.A.C.C.  
George J. Smith, M.D., F.A.C.C.

Lori Quinn-Tate, R.N., M.N.  
Jeffrey J. Stein, A.C.N.P.  
Nathan C. Freeman, PA-C

**REQUEST FOR PROTECTED HEALTH INFORMATION**

Date: \_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_

**I hereby authorize you to release to Heart & Vascular Clinic protected health information including the records of any treatment or examination rendered to me. Thank you.**

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

PURPOSE OF REQUEST: \_\_\_\_\_ EXPIRATION DATE OF REQUEST: \_\_\_\_\_

RECORDS REQUESTED: \_\_\_\_\_

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> H & P   | <input type="checkbox"/> CONSULT  | <input type="checkbox"/> D/C SUMMARY                |
| <input type="checkbox"/> LAB WORK                                      | <input type="checkbox"/> PA <input type="checkbox"/> PV DOPPLER                         | <input type="checkbox"/> EKG TRACING                |
| <input type="checkbox"/> CXR   | <input type="checkbox"/> PFT W/DLCO   | <input type="checkbox"/> ECHO                       |
| <input type="checkbox"/> CVE/CAROTID DOPPLER                           | <input type="checkbox"/> HOLTER   | <input type="checkbox"/> EVENT MONITOR              |
| <input type="checkbox"/> STRESS TEST EKG PART                          | <input type="checkbox"/> STRESS TEST NUC PART   | <input type="checkbox"/> STRESS TEST ECHO PART      |
| <input type="checkbox"/> CATH LAB REPORTS                              | <input type="checkbox"/> CATH <input type="checkbox"/> PM <input type="checkbox"/> AICD | <input type="checkbox"/> PCI:PTCA/STENT/ROTA/BRACHY |
| <input type="checkbox"/> PERIPHERALS <input type="checkbox"/> CAROTIDS | <input type="checkbox"/> CABG <input type="checkbox"/> CEA REPORTS                      | <input type="checkbox"/> ANGIO FILMS / CD           |

**SPECIFY RECORDS: CHECK and then INITIAL to specify which type of information IS to be disclosed.**

**MEDICAL INFORMATION** \_\_\_\_\_  **DRUG/ALCOHOL INFORMATION** \_\_\_\_\_

**PSYCHIATRIC INFORMATION** \_\_\_\_\_  **RESULTS OF AN HIV BLOOD TEST** \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

*You have the right to revoke this authorization in writing to the extent that the practice has acted in reliance upon this authorization. You can submit your revocation in writing to the office supervisor at the appropriate location noted above.*

**Please forward protected health information to the office indicated below:**

- \_\_\_\_\_ 64040 Highway 434, Suite 200 • Lacombe, LA 70445 • (985) 892-9233 • FAX (985) 892-8916
- \_\_\_\_\_ 433 Plaza Street, 2<sup>nd</sup> Floor • Bogalusa, LA 70427 • (985) 732-3896 • FAX (985) 732-5501
- \_\_\_\_\_ 42078-A Veterans Ave./Business 51 • Hammond, LA 70403 • (985) 419-1884 • FAX (985) 419-1885