OUTPATIENT MEDICAL CENTER, INC.

CONSENT TO RELEASE OF INFORMATION
WAIVER OF CONFIDENTIALITY

I understand that treatment, payment, enrollment, or eligibility for benefits provided by OMC is not conditioned on whether I sign this authorization. Such information cannot be released without authorized written permission, except as required by law.

I UNDERSTAND that the information in the record of:

Name:		DOB:
Address:		SS#:
City:	State:	Zip Code:

☐ Natchitoches OMC
1640 Breazeale Springs Street
Natchitoches, LA 71457
Ph: 318.352.9299
Fax: 833.448.3055

☐ Leesville OMC
908 10th Street
Leesville, LA 71446
Ph: 337.238.1274
Fax: 833.448.3055

☐ Tallulah OMC
804 North Beech Street
Tallulah, LA 71282
Ph: 318.574.1453
Fax: 833.448.3055

☐ School Based OMC
1500 Gold Street
Natchitoches, LA 71457
Ph: 318.238.7440
Fax: 833.448.3055

☐ Release Information **TO** ☐ Obtain Information **FROM**

Name:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	

I authorize the release of the following protected Health Information:
(Place an **"X"** in the box/boxes that apply to the information you want to released or you want to obtain)

☐ Entire Records ☐ Only Medical Reports ☐ Only Behavioral/Psychology ☐ Only Dental Records
☐ Only Physical Therapy Records ☐ Medical History, Examination, Reports
☐ Other:_____

I understand that I have the right to refuse or disclose HIV Test results. ☐ I DO NOT AUTHORIZE release of HIV test results.

The above listed Information is to be release for the specific purpose as indicated in the box/boxes below.
☐ Medial Evaluation/Care ☐ Changing Providers ☐ Legal Investigation or Action
☐ Other:_____

I understand that my permission to release this may be canceled at any time except when the information has already been released. My permission to release this information will expire: ____/_____/_____. I understand that if I do not specify an expiration date, this authorization will expire one (1) year from the date on which it was signed. I, further understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

The undersigned certifies that he/she is the parent/guardian/representation of the person listed above and has the legal authorization to sign on behalf of the person, whether by court order, or by operation of law:

_____
Signature of Patient or Legal Representative **Date**

_____
Witness **Date**

***** ALL MEDICAL RECORDS SHOULD BE FAXED TO 833-448-3055 *****