Jill E. Gibson, M.D.
106 Highland Park Plaza • Covington, LA 70433
810 Riverside Drive • Franklinton, LA 70438
Phone: 985-898-5990 Fax: 985-590-3719

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I,_____ _____
Full Name **Date of Birth**

Hereby authorize:

_____
Name of Hospital, Physician, Service Agency or Third Party

_____
Address **City** **State** **Zip**

To release a copy of my medical records to:

The Office of Dr. Jill E. Gibson, M.D._____
Name of Hospital, Physician, Service Agency or Third Party

106 Highland Park Plaza **Covington** **LA** **70433**
Address **City** **State** **Zip**

Notice: You may also come into the office and review your chart. However, you will be charged an office visit that will range in price depending on the level of the visit. The doctor will perform this coding. If you would like to review your chart, please call our office for appointment time and estimated pricing.

Purpose for Release □**Changing Doctors** □**Insurance** □**Legal** □**Other**

□ Diagnosis, including those related to alcohol and drug abuse, if any

□ Procedures	□ History and Physical	□ Clinic Notes
□ Hospital Admissions	□ Emergency Record	□ Consultation Reports
□ Psychiatric Record	□ Lab and X-Ray	□ Progress Notes
□ Surgery/Pathology Reports	□ Abstract of Hospital Records	□ Complete Medical Record

□ Other _____

Start Date of Records _____ **End Date of Records** _____

The Federal confidentiality rules (42 CFR Part2) prohibits the disclosure of records that may include alcohol and drug abuse information unless expressly authorized by patient. To authorize release of this information, please sign the following: I,_____ authorize the release of drug and alcohol information.

I,_____ authorize the release of HIV test results.

I hereby waive and release any member of the staff of Jill E. Gibson, M.D. from any restriction or privilege imposed by law, in disclosing or revealing any professional record, observation or communication. This authorization is subject to revocation in writing any time except to the extent that Jill Gibson, M.D. has already taken action in reliance on it. If not previously revoked in writing this consent will terminate 6 months from the date of the completion of this form.

Patient Date

Authorization Representative/Relationship Date

Witness Date