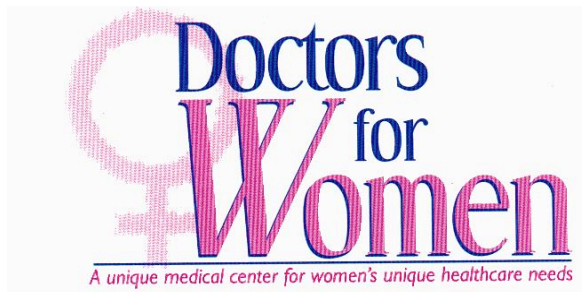


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**MEDICAL RECORDS RELEASE FORM**

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed because of this authorization may be subject to re-disclosure by the recipient and will therefore no longer be protected by federal privacy regulations.

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

**Address:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

\_\_\_\_\_ **phone:** \_\_\_\_\_

**Release Information to:** \_\_\_\_\_

\_\_\_\_\_  
**Phone** \_\_\_\_\_ **Fax** \_\_\_\_\_

**Release Information from:** \_\_\_\_\_

\_\_\_\_\_  
**Phone** \_\_\_\_\_ **Fax** \_\_\_\_\_

Information to be released:  All Records  Progress Notes  Labs Other: \_\_\_\_\_

Reason for request:  Changing Physicians  Self  Specialist Consultation Other: \_\_\_\_\_

- I understand that if the person or entity receiving my health information is not a health plan or health care provider covered by federal privacy regulation, the health information may be re-disclosed by the recipient any may no longer be protected by federal or state law.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.
- I understand that this authorization will expire 30 days after date listed below. I understand that I may cancel this authorization at any time by notifying the healthcare provider in writing. I understand that my cancellation will not affect any actions taken by the healthcare provider before receiving my cancellation.
- I understand that I may have a copy of this authorization.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**\* There will be a processing charge for this request. The fees are as follows:**

1-25 pages \$25.00  
26-500 pages \$.50 per page  
Handling Charge \$15.00

Make Check Payable to:  
**Doctors for Women**

**Date of Release:** \_\_\_\_\_ **Authorized by:** \_\_\_\_\_

**Copied / faxed / released by:** \_\_\_\_\_