

Authorization for Release of Medical Records

I, _____ do hereby authorize

PHYSICIAN NAME: _____

PHYSICIAN'S FAX _____ PHYSICIAN'S PHONE _____

to furnish _____ **Dr. Tami LaGraize**
OR
_____ **Dr. Chris LaGraize**

information regarding my past/present medical history including diagnosis' and records of my treatment and examination rendered to me:

- 1) from _____ to _____,
- 2) _____ most recent lab results with in the last _____ months
- 3) _____ most recent test results with in the last _____ months
- 4) _____ All information in your files

Please fax the above requested information to (337) 289-9702 or mail to 155 Hospital Dr. Ste. 410, Lafayette, LA 70503.

Date Patient Signature

Address

Date of Birth City State Zip