LAFAYETTE
INTERNAL MEDICINE CLINIC

Telephone: (337) 504-3335 **Fax: (337) 504-4795**

HIPAA

Authorization for Individuals Involved in the Care of a Patient

I give LIMC permission to release medical information to the following individuals:

Name: _____ Relationship to patient: _____Tel #: _____

Name: _____ Relationship to patient: _____Tel #: _____

Name: _____ Relationship to patient: _____Tel #: _____

Authorization to Leave a Detailed Message

I hereby authorize my provider or other representative of LIMC to leave a detailed message concerning my lab results, insurance/billing information or questions, appointments, surgery, prescriptions, or any other issues on the following devices:

Please check all that apply and write appropriate phone number in the blank:

___ Answering machine at home: _____

___ Voicemail at work: _____

___ Cell Phone: _____

___ Other: _____

RECEIPT OF LIMC POLICIES

By signing below, I agree that I have received and read the documents listed below. I had the opportunity to ask questions and all were answered to my satisfaction. The above authorizations are valid until such time as I revoke them in writing.

1. **PATIENT POLICY**
2. **FINANCIAL POLICY**
3. **RECEIPT OF PRIVACY PRACTICES**

Patient Name:_____ DOB:_____

Signature:_____ Date: _____

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