LAFAYETTE INTERNAL MEDICINE CLINIC
4809 Ambassador Caffery Pkwy - Suite 410
Lafayette, LA 70508

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: _____________________