Causeway Interventional Medicine LLC
3749 N. Causeway Blvd., Ste.B
Metairie, LA 70002

MEDICAL RELEASE FORM RECORDS
(504) 828-8241 / F (504) 828-8243

Patient's Full Name: _____

Date of Birth: _____/_____/_____

I hereby authorize the release of information to be released to Causeway Interventional Medicine LLC.

Facility/Entity of Information to be released from:

Name: _____

Phone: _____ Fax: _____

Address:
_____
_____

Medical Information Requested:

[ ] All Records

[ ] Specific Records from _____ to _____

[ ] Immunizations & Physical Examinations

[ ] Radiology Films and Reports (X-Rays, Mammograms, Ultrasound, CT, MRI, etc.

[ ] Other: _____

Signature of Patient: _____

Date signed: _____

This release authorized the disclosure of records for ONE Year from the date above. I understand that these records are protected under Federal and /or State law, and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and / or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS) related complex (ARC) of Humane Immune Deficiency Virus (HIV) Infection. I understand I have the right to revoke this consent at any time, unless the facility which is to make the disclosure of information has already done so reliant on the consent.