PHILIP MEYER, D.O.
Medical Director
5000 Ambassador Caffery
Building 10
Lafayette, Louisiana 70508
(337) 993-8300
Fax (337) 521-9159

AUTHORIZATION TO INDIVIDUALS

I, ____, give all physicians and professional staff employed by **Women's Imaging Centre** permission to disclose the private health information set forth below to the following people at the request of one or more of these individuals.

The specific information these persons may receive is as follows: ______________________________

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Please Print: Name | Relationship

Name	Relationship
____	________________________
____	________________________
____	________________________
____	________________________

I also give **Women's Imaging Centre** permission to leave a message(s) on my answering machine if they should need to remind me of an appointment, change an appointment, etc…and are unable to reach me in any other way.

__________ Yes or __________No

I understand that **Women's Imaging Centre** will not release any information to any person(s) not listed above.

In addition, I understand or acknowledge the following:

1. I have the right to revoke this Authorization at any time by giving **Women's Imaging Centre** a written notice at the address set forth above.
2. I have received **Women's Imaging Centres'** Notice of Privacy Practices.
3. My private health care information may be subject to re-disclosure by one or more of the persons named above and such will no longer be protected.

This Authorization shall expire on the _____ day of ______________________, 20______.

Please Print

Patient Name____ D.O.B.______________________

____ ____

Signature Date

In the event the Authorization is being executed by a personal representative, guardian or parent, please print your name and relationship to the patient.____