NORTHSHORE
PLASTIC SURGERY

Authorization for Release of Information/Medical Records Release

I, _____, DOB: ____/____/_____, SS# _____-_____-_____, hereby authorize Benjamin J. Boudreaux, M. D. and/or Jeffrey R. Claiborne, M. D. to release information to any hospital and/or physician to which I may be referred by this office. In addition, I authorize Benjamin J. Boudreaux, M. D. and/or Jeffrey R. Claiborne, M. D., to request and obtain my medical records from any hospital and/or physicians who have treated me.

Signature: _____

Printed Name: _____ Date: _____/_____/_____

Relation to patient: _____

Witness: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice by calling (985) 237-6050 or by requesting one at the following office:

Northshore Plastic Surgery, LLC
Benjamin J. Boudreaux, M. D.
Jeffrey R. Claiborne, M. D.
3401 East Causeway Approach
Mandeville, LA 70448

Date: _____ **Signature*: _____**

Print Name: _____

***As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.**

Date: _____ **Signature: _____**

Relationship: _____