Vicki Steen, MD
Scott Striplin, MD
Kira Clement, MD
77 Starbrush Circle
Covington, LA 70433

PATIENT INFORMATION RELEASE AUTHORIZATION

Full Patient Name: _____ Date of Birth: _____

I hereby authorize Women's Health & Wellness, LLC. To release/provide protected health information and/or financial/billing information to the following individuals:

DATE AUTHORIZED	NAME	RELATIONSHIP	PHONE NUMBER	DATE RESCINDED	PATIENT'S INITIALS

I understand that I may rescind all or some of the above authorization(s); however, in order to implement the change, I must personally visit the Clinic, provide the above-requested information and enter my initials.

I authorize Women's Health & Wellness, LLC. To release my protected health information to other healthcare providers, healthcare payors, government agencies, and other healthcare organizations as reasonably necessary for continuity of care, reimbursement, audit and/or quality of care-related purposes.

_____ _____ _____

Patient's Printed Name Signature Date