

4133460  
Ochsner

12040351  
2/23/2016 8:25:12 AM PAGE 2/002

2992329

From: Northshore Intervention

985-892-6857

FAX  
 FAX SERVER  
 FEB 23 2016 15:03  
 #822 P.001/001  
 Initials:

504  
847-2459

### NORTHSHORE INTERVENTIONAL PAIN MGMT, A.P.M.C.

Office 985-809-1997 Fax 985-809-1664  
Authorization for the Use and Disclosure of Protected Health Information

Patient Legal Name Jeffrey Bodin Birthdate 5/22/1971  
 Address 528 Beau Chene Dr City Manorville  
 State LA Telephone Number 985-264-1080

I hereby authorize Northshore Interventional Pain Management Center  Disclose  Request  
 Medical record information (protected health information) of the patient listed above to/from:  
 Name/Title Dr. Lyserko, Dr. Artuk, Dr. Richard Gussler, Dr. Kristin Mearns, Dr. Fay  
 Address Dr. William L. Term, Dr. Sherril (asep) Dr. Kirk Pinsky  
 Purpose: \_\_\_\_\_  
 For treatment date(s): \_\_\_\_\_

Type of Access Requested:

- |  |  |   |   |
|--|--|---|---|
| <input checked="" type="checkbox"/> Copies of the record     | <input checked="" type="checkbox"/> Entire Record        | <input checked="" type="checkbox"/> H & P         | <input checked="" type="checkbox"/> Physicians Orders |
| <input checked="" type="checkbox"/> Inspection of the record | <input checked="" type="checkbox"/> Consult Report       | <input checked="" type="checkbox"/> Admit Notes   | <input checked="" type="checkbox"/> Rehab Services    |
|  | <input checked="" type="checkbox"/> Operative Report(s)  | <input checked="" type="checkbox"/> Face Sheet    | <input checked="" type="checkbox"/> Discharge Summary |
|  | <input checked="" type="checkbox"/> Patient Care Summary | <input checked="" type="checkbox"/> Nursing notes | <input checked="" type="checkbox"/> Progress Notes    |
|  | <input checked="" type="checkbox"/> Medication Record    | <input checked="" type="checkbox"/> MRI's         | <input checked="" type="checkbox"/> CT Scans          |
|  | <input checked="" type="checkbox"/> X-rays               | <input checked="" type="checkbox"/> Myelogram     |   |

Other Please send last 2 office notes

This authorization shall expire upon the following expiration date or event (if I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed):

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company for services already rendered.

The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

Fees/Charges will comply with all laws and regulations applicable to release of information.

I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to ensure health care treatment.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient or Legal Representative Jeffrey Bodin Date FEB 19 2016

If signed by a Legal Representative, relationship to patient \_\_\_\_\_

Signature of Witness Kirk Pinsky Date 2-19-2016

7015 Hwy. 190 E. Svc. Rd., Suite 101 Covington, LA 70433

ACCT#- 8456 DR- AC LOC- OF  
 DOR: 05/22/1997  
 BODIN, JEFFREY D  
 CHRT#- (985) 845-0969  
 FC- B INS(BLU/ / ) H/S- N

E/100p53  
Cliff 2/24/16