4133460 1204030[illegible] 2598329

Ochsner

2/23/2016 8:25:12 AM PAGE 2/002 Fax Server

From:Northshore Intervention 985+892+6857 02/22/2016 15:03 #822 P.001/001

FEB 23 2016 Initials:

504-842-2459

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 5/22/97 ✓

Address 528 Beau Chene Dr City Mandeville

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:

Dr. Lysenko, Dr. Arvik, Dr. Richard Guillot, Dr. [illegible] Meads, Dr. Foy

Name/Title Dr. William Lterman, Dr. Sherri Casey, Dr. Rick Casey

Address

Purpose:

For treatment date(s):

Type of Access Requested:

✓ Copies of the record

✓ Inspection of the record

Selected portions of PHI:

✓ Entire Record
✓ Consult Report
✓ Operative Report(s)
✓ Patient Care Summary
✓ Medication Record
✓ X-rays
✓ H & P
✓ Admit Notes
✓ Face Sheet
✓ Nursing notes
✓ MRI's
✓ Myelogram
✓ Physicians Orders
✓ Rehab Services
✓ Discharge Summary
✓ Progress Notes
CT Scans

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 [signature] Date FEB 19 2016

If signed by a Legal Representative, relationship to patient

Signature of Witness [signature] Date 2-19-2016

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

```
ACCT#-        8456 DR- AC  LOC- OF
                   DOB: 05/22/1997
  BODIN, JEFFREY D
CHRT#-             (985)845-0969
FC- B   INS(BLU/   /   )  H/S- N
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E/100p53
[illegible] 2/24/16