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RELEASE OF INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____
Social Security Number: _____

I hereby authorize the release of:

- | | |
|------------------------------|------------------------------------------|
| Lab Reports () | Discharge Summaries () |
| X-rays and X-ray reports () | Pathology Reports () |
| Progress Notes () | Correspondence from other Physicians () |
| Operative Reports () | Other _____() |

From: _____
Address: _____

To: **LINCOLN SURGICAL ASSOCIATES, APMC**
411 E. Vaughn, Suite 200
Ruston, LA 71270
Or fax to: 318-513-1599

1. I understand that the purpose for this release is for the continuity of my care
2. I shall regard a photocopy of this document as valid as the original.
Yes () No ()
3. I understand that these documents shall be mailed, "faxed", hand delivered, or reported over the phone.
4. I understand that my medical records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law.
5. This document shall be valid for 1 year from the date of signature.

Signature of Patient or Legal Representative

Today's Date

Relationship to Patient

Any redisclosure of the following material without the written permission of the person to whom it pertains is strictly prohibited by federal law.

! Thank you !