



VISITATION FORM

Patient Name: _____

Patient Address: _____

Date of Birth: _____

Age: _____

Gender: _____

Telephone Number: _____

- Race: American Indian/Alaska Native
 Asian
 Black/African American
 Hispanic
 Native Hawaiian/Pacific Islander
 White (Non-Hispanic)

Ethnicity: _____

Today's Date: _____



1028 FORUM ROAD • BROUSSARD, LA 70518 • PHONE 337.704.0891 • FAX 337.704.0924

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act

This form authorizes release of information requested in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 in addition to those routine uses disclosures of the information authorized by HIPAA and in accordance with the Notice of Privacy Practice.

Patient Name: _____

Date of Birth: _____ **Telephone Number:** _____

Information may be released to: _____
Purpose for Release of Information: To: The person or entity responsible for payment for healthcare services, and/or involved in my treatment, including but not limited to My Employer, and any entity working with my Employer, such as an insurer, case manager or Third Party Administrator for treatment or payment purposes. Treatment and payment purposes include, but are not limited to employment related functions, such as fitness for duty, drug screening, and worker's compensation or similar programs established by law that provide benefits for work related injuries or illnesses without regard to fault.

Name of health care provider or entity to release this information: XstremeMD

Address of above entity: 1028 Forum Drive Broussard, LA 70518

Information to be released:

Expiration Date: This Authorization expires 2 years from date of signature below, unless otherwise revoked in writing.

_____ I hereby authorize the release of All MEDICAL RECORDS AND INFORMATION pertaining to my care and treatment for my Injury or Illness on the visit of _____ (DATE), and any subsequent visits or other encounters for such Injury or Illness, including but not limited to visit notes (history, physical examination and assessment), test results of any kind, radiology reports, referrals, consultant notes, billing records, insurance records, and ALL records created or received by XstremeMD for the care and treatment provided on all dates relative to my Injury or Illness.

_____ I hereby authorize the release of my Medical Records and Information through the XstremeMD portal, which allows the recipient access to my medical records, including return to work forms and work related case management reports.

_____ Limitation on release of information:

Acknowledgement

I request that health information regarding my care and treatment be released as set forth on this form and understand: 1) This authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment, and confidential HIV related information only if I sign my name on the line below. 2) I have the right to revoke this authorization at any time by writing to XstremeMD at: 1245 South College Road, Suite 101, Lafayette LA 70503. 3) I understand that signing this authorization is voluntary. I understand that information released pursuant to this authorization maybe subject to re-disclosure by the recipient and may no longer be protected by HIPAA. 4). My treatment will not be conditioned upon my authorization of this disclosure except as allowed by HIPAA for health care services that are solely for the purpose of creating protected health information for disclosure to a third party, like my Employer for purposes such as pre-placement physicals, drug tests, and fitness-for-duty examinations, and failure to provide authorization may result in termination of the patient relationship.

Additional Authorization for release of information:

I understand that this information may be used to adjust, describe, or report matters about my care and treatment to persons entitled to receive this information and I expressly authorize XstremeMD to engage in ORAL COMMUNICATIONS regarding my medical records and information as set forth above.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. A photocopy of this authorization shall have the same validity as the original.

Patient Signature

Date

Witness Signature

Date



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Turnaround time for COVID-19 swab results is at least 72 hours.

Results will not be given on weekends.