Julie Foreman, MD.

1211 Coolidge Street, Suite 401

Lafayette, La 70503

337-541-1700 / 337-534-4992

**Records Request / Release Authorization**

**Obtain Records From:**

 \*\*INCLUDING ALL WRITTEN, ELECTRONIC, VERBAL RECORDS\*\*

**Patients Name:**

**Date of Birth:**

**Send Records to: Dr. Julie Foreman**

 **FAX: 337-534-4992**

 **EMAIL:** **office@julieforemanmd.com**

 **MAIL: 1211 Coolidge St. Suite 401**

 **Lafayette, LA 70503.**

I hereby Authorize Dr. Foreman to obtain copies of any and all of my medical records pertaining to my medical history and treatment. This authorization may include hospitals, physicians, nurses, insurance companies and their representatives and any institution, agency and/or individual representing me.

I further agree that this authorization shall be valid and effective indefinitely unless and until it is revoked by me in writing and that a photocopy of this authorization may serve as an original.

**Dates or records :**  From: **ALL**  To: **ALL**

**Request expires:**

**Patient Signature: Date:**