

**STATE OF LOUISIANA
MEDICAL AUTHORIZATION**

To Whom it May Concern:

I, _____ consent and give permission to: _____
to examine inspect, secure and obtain copies of all records, reports, x-rays, test results, any and
all hospital charts, nurse's notes and records that you have in your possession in connection with
my examination and/or treatment at _____ and or treatment by Dr.
_____.

A photostatic copy of this shall have the same effect as the original.

This authorization does not allow and strictly prohibits and communication whatsoever with any
treating physicians or their staff, including but not limited to in-person and/or verbal
communication.

_____, Louisiana, this _____ day of _____, 2002.

Patient

Sworn to and subscribed before me this

_____ day of _____, 2002.

Notary Public