INTERVENTIONAL
SPINE & REHAB
OF LOUISIANA

ISRLouisiana.com
PH 225-263-0600 FAX 225-263-0601
4021 WE Heck Ct. Building M-1 Baton Rouge, LA 70816

MARK JOHN, M.D.
PHYSICAL MEDICINE & REHABILITATION
INTERVENTIONAL PAIN MANAGEMENT

Medical Disclosure Form

Please read **CAREFULLY** and check **ONLY ONE** (1) box.

Patient Name: ______________________________ DOB: ______________________

☐ I authorize Interventional Spine and Rehabilitation of Louisiana to disclose all information in my records to the following individuals (listed below). I understand that my medical records may contain information that indicates that I may have a communicable disease, with may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus (HIV), also known as acquired immune deficiency syndrome (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning my identity and release ISRL and its employees from liability in connection with the release of the information contained therein.

☐ I authorize Interventional Spine and Rehabilitation of Louisiana to only release the following information (listed on the lines below) to the following individuals (listed below). (For example, appointment date and time, procedure date and time).

____

____

____

☐ I do not authorize Interventional Spine and Rehabilitation of Louisiana to disclose any information to any individuals. This does not include your emergency contact.

Name	Relation
Name	Relation
Name	Relation
Name	Relation

I understand I have the right to revoke this authorization at any time. I understand that information disclosed to any recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

______________________________ ______________________

Patient Signature Date

Revised 04/30/2021