PARADIGM
HEALTH SYSTEM
A NEW DIRECTION IN HEALTHCARE

RECORDS RELEASE AUTHORIZATION

I Hereby Authorize:

Name: .....

Street Address: .....

City, State, Zip: .....

Phone: .....

Fax: .....

To Release My Medical Records Currently in His/Her Possession to:

Paradigm Health System
64301 Highway 434
Lacombe, LA 70445
(985) 882-4500

Northlake Neurological Institute
64301 Highway 434
Lacombe, LA 70445
(985) 882-4500

Signature: .....

Print Name: .....

Date: ..... Date of Birth: .....

Witness: .....