

LOUISIANA STATE BOARD OF PRACTICAL NURSE EXAMINERS  
131 AIRLINE DRIVE, SUITE 301  
METAIRIE, LOUISIANA 70001-6266  
(504) 838-5791  
Fax: (504) 838-5279  
www.lsbpne.la.gov

***PATIENT CONSENT FORM  
TO DISCLOSE MEDICAL RECORDS AND INFORMATION***

I, the undersigned, below-identified PATIENT, do hereby authorize the individual or institutional HEALTH CARE PROVIDER designated below to disclose and furnish any and all information and records, and any reports or summaries thereof, relating to my evaluation, diagnosis, treatment and prognosis by or under the care of the HEALTH CARE PROVIDER to the Louisiana State Board of Practical Nurse Examiners (the "Board") for the purpose of permitting the Board to be initially and periodically advised of my diagnosis, treatment and prognosis for any condition, including but not limited to alcoholism and drug abuse which may impair my capacity to practice practical nursing with reasonable skill and safety to patients or to myself.

This Consent is made and given in conformity with and pursuant to 42 U.S.C. ' 290dd-2(b)(1) and former ' 290ee(3)(b)(1) and regulations promulgated thereunder. 42 C.F.R. ' 2.3133 but is intended to be effective to consent to the disclosures authorized herein whether or not the HEALTH CARE PROVIDER is subject to the provisions of 42 C.F.R. Part 2.

This Consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this Consent will terminate upon five (5) years after enactment.

**HEALTH CARE PROVIDER**

**PATIENT**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date