

# Authorization to Release Medical Information

---



**Patrick Keating, MD**

**Effective  
January 1, 2026**



**Desai Eye Care**  
155 Hospital Drive, Suite 300  
Lafayette, LA 70503  
Phone: (337)235-6263  
Fax: (337)234-9629

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

Date of birth: \_\_\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

I authorize the release of the following protected health information:

- Office Notes                       Pathology Reports                       Radiology Reports  
 Laboratory Reports                       Other: \_\_\_\_\_

The purpose for this request to release medical information is:

- Medical Care/ Treatment                       Insurance                       Other: \_\_\_\_\_

I hereby authorize Anu Gupta Desai, M.D., Emily Prouet, M.D. and Patrick Keating, M.D. **to obtain copies of any and all medical records** pertaining to my medical history and treatment. This authorization may include hospitals, physicians, nurses, insurance companies and their representatives, and any individual, agency and or individual representing me.

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

---

Patient/ Representative Signature:

Date:

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and also complete the following:

---

Print Name:

Relationship to Patient: