Authorization to Release Protected Health Information to **The Pediatric Place, LLC**

18367 Perkins Road East
Baton Rouge, LA 70810
Tel (225) 636-5437
Fax (225) 636-5547

Patient (Last, First, MI): _____ Gender: ☐ F ☐ M

Date of Birth: _____/_____/_____ SSN _____ Home Phone: (_____) _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Authorization to Release Protected Health Information
I hereby authorize the following organization to release the information identified in this authorization form:

Medical Facility: _____ Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please send to: ☐ Dr. Barrient ☐ Dr. Busenlener ☐ Dr. Philippe

The Pediatric Place, LLC, 18367 Perkins Road East, Baton Rouge, LA 70810
Tel: 225-636-5437 Fax: 225-636-5547

Information to be Released – Covering the Periods of Health Care
From Date: _____/_____/_____ Through Date: _____/_____/_____

Please Indicate the Information to be Released Below:
☐ Complete Health Record ☐ Immunization Records
☐ Other (Please Specify) _____

Purpose of the Requested Disclosure of Protected Health Information:
I am authorizing the release of my Protected Health Information for the following purpose(s):
☐ Transfer of Medical Care ☐ Other _____

Right to Revoke Authorization:
Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to The Pediatric Place, LLC – ATTN: Medical Records Manager at 18367 Perkins Road East, Baton Rouge, LA 70810. Unless revoked, this authorization will expire 6 months from the date of this release.

Re-disclosure:
I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Personal Representative Who May Request Disclosure:
I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form.

Signature:_____ Date: _____/_____/_____

Printed Name: _____ Relation to Patient: _____