Authorization of Release of Medical Records

Patient Name:	DOB:
Address:	
Phone:	

I authorize the release of medical records: ☐ To: ☐ From: The Pediatric Place, LLC
18367 Perkins Rd E
Baton Rouge, La 70810
P: (225) 636-5437
F: (225) 636-5547

☐ To: ☐ From: ____________________
____
____
P: ____________________
F:

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 ☐ Other (Please Specify): __________

☐ Immunization Records

Purpose of the Requested Disclosure of Protected Health Information

☐ 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. Unless revoked, this authorization will expire six 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: