Authorization to Release or Obtain Health Information

Patient Name	Request Date
Mailing Address	Date of Birth
City/State/Zip	Social Security #

(including paper, oral and electronic information)

I authorize:

Name: **PEDIATRIC ASSOCIATES OF LAFAYETTE, LLC**

Mailing Address: City, State, Zip Code: **437 HEYMANN BLVD, LAFAYETTE, LA 70503**

Telephone Number: **(337) 289-8989** Fax Number: **(337) 289-8999**

❒ **TO RELEASE Information TO OR** ❒ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: ______________________________

Mailing Address: ______________________________

City, State, Zip Code: ______________________________

Telephone Number: ____________________ Fax Number: ____________________

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❒ Further Medical Care ❒ Personal ❒ Legal Investigation or Action ❒ Changing Physicians

❒ Research related treatment ❒ Creating health information for disclosure to a third party.

❒ Other: (Specify)______________________________

I authorize the release of the following protected health information.

(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

❒ Medical Records from last one (1) year ❒Entire Record ❒Treatment or Tests ❒Surgical Reports

❒ Immunization Records ❒Prescriptions ❒Laboratory Reports ❒X-ray Reports

❒ Medical History, Examination, Reports ❒ MR/DD Records ❒ Hospital Records including Reports

❒ Complete Designated Record Set Dates of Service:____________________

❒ Other: ______________________________

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records. ❒ Not Applicable

❒ Alcoholism † ❒ Drug Abuse † ❒ Mental Health ❒Vocational Rehabilitation ❒ Genetics ❒ HIV (AIDS)

❒ Sexually Transmitted Diseases ❒ Psychotherapy Notes

❒ Other______________________________

This authorization shall expire on ____________________(date or event) and is needed for the period beginning ____________________ and ending ____________________.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read and understand this form.

______________________________ ____________________

Signature of Individual or Personal Representative Authorized by Law Date

FOR FACILITY USE:

DATE RECEIVED:____________ DATE INFORMATION RELEASED:____________ CHART#__________ PERSON SENDING RECORDS:____________