REQUEST FOR RELEASE / EXCHANGE OF MEDICAL RECORDS

This form authorizes the release or exchange of your child's medical and/or behavioral health records to or from Lagniappe Pediatrics Rehab and Therapy. A separate form is required for each provider or facility. This authorization may be revoked in writing at any time. Revocation will not apply to information already released in reliance on this authorization.

Patient / Client Information

Client's Last Name: _____ **First Name / Preferred Name:** _____ **Date of Birth (MM/DD/YYYY):** _____

Medicaid ID / Insurance ID: _____ **Primary Diagnosis:** _____ **Date of Last Visit (if known):** _____

Parent / Legal Guardian Name: _____ **Relationship to Client:** _____

Home Address: _____ **City:** _____ **State / Zip:** _____

Phone Number: _____ **Email Address:** _____

Authorization to RELEASE Records (From Lagniappe to Another Provider)

I authorize Lagniappe Pediatrics Rehab and Therapy to release records to:

Provider / Facility Name: _____ **Provider Type (e.g., Pediatrician, School, Hospital):** _____

Address: _____ **City:** _____ **State / Zip:** _____

Phone Number: _____ **Fax Number:** _____

Records to be released (check all that apply):

[ ] Evaluation / Assessment Reports
[ ] Treatment Plans and Progress Notes
[ ] ABA Behavior Intervention Plan (BIP)
[ ] Therapy Session Notes (OT / PT / SLP / Feeding)
[ ] Psychiatric / Behavioral Health Notes
[ ] Medication Records
[ ] Discharge Summary
[ ] Physician Orders / Referrals
[ ] School / IEP Records
[ ] Immunization Records
[ ] Lab / Diagnostic Results
[ ] All Records in File

Date Range of Records Requested (From): _____ **To:** _____

Purpose of Release: [ ] Continuity of Care [ ] School / Educational Planning [ ] Legal / Court Proceedings [ ] Insurance / Billing [ ] Personal Use [ ] Other: _____

Authorization to RECEIVE Records (From Another Provider to Lagniappe)

I authorize the following provider or facility to release records to Lagniappe Pediatrics Rehab and Therapy:

Provider / Facility Name: _____ **Provider Type:** _____

Address: _____ **City:** _____ **State / Zip:** _____

Phone Number: _____ **Fax Number:** _____

Records to be received (check all that apply):

[ ] Evaluation / Assessment Reports
[ ] Prior Treatment Plans and Notes
[ ] Diagnosis Records / CDE
[ ] School Records / IEP / 504 Plan
[ ] Psychiatric / Behavioral Health Records
[ ] Medication Records
[ ] Physician Orders / Referrals
[ ] Discharge Summary
[ ] All Records in File

Date Range of Records Requested (From): **To:**

Purpose of Receipt: [ ] Initial Evaluation [ ] Treatment Coordination [ ] ABA Assessment [ ] Insurance / Prior Authorization [ ] Other: _____

Format and Delivery

Preferred Format: [ ] Electronic (secure fax) [ ] Electronic (secure email) [ ] Paper / Mail [ ] Pick up in person

Please send / receive records by: _____ (date)

Special Instructions or Additional Notes:

Expiration and Acknowledgment

This authorization will expire one (1) year from the date of signature below, or upon completion of the requested records exchange, whichever comes first. I understand I have the right to revoke this authorization at any time by submitting a written request to the Clinical Coordinator at Lagniappe Pediatrics Rehab and Therapy. Revocation will not apply to information already released or received in reliance on this authorization.

I understand that my child's treatment at Lagniappe Pediatrics Rehab and Therapy is not conditioned upon my signing this authorization, except where the records exchange is necessary to provide the requested services.

Parent / Legal Guardian Signature and Date: **Printed Name:** **Relationship to Client:**

Office Use Only

Request Received By: **Date Received:** **Records Sent / Received On:** **Staff Initials:**

[ ] Records sent via fax [ ] Records sent via secure email [ ] Records received and filed in chart [ ] Unable to fulfill — reason: _____