



PEDICONS, INC.

**Authorization to Release Health Information
(Including paper, oral and electronic information)**

By signing this form, I authorize you to release confidential health information about my child's/myself, by releasing a copy of my medical records, or a summary or narrative of my child's/myself protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ **DOB:** _____

Parent/Guardian: _____

Purpose of Release: Medical Insurance Legal Other _____

Put an "X" in box for items to be released.

Complete Records

- | | | |
|--|---|---|
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Care Plan | <input type="checkbox"/> Medication Record |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Hospital/Operative Reports | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Other (please state) |

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

- | | | |
|--|--|---|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Genetics |
| <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Psychotherapy Notes | <input type="checkbox"/> Other (please state) |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Alcoholism | _____ |

I authorize the following persons to make these disclosures of my health information:

Name: _____

Address: _____

Phone: _____

Fax: _____

I authorize the following persons to receive these disclosures of my health information:

**KID MED NORTH 5151 Plank Rd., STE 38 Baton Rouge, LA 70805
(O) 225-356-2006 (F)225-355-1144**

This authorization shall expire on _____ (date or event).

I understand that if I do not specify an expiration date, this authorization will expire one (1) year from the date on which it was signed.

Signature of Patient/Parent/or Guardian:

_____ Date: _____