PEDIATRICS
AT
DELMONT

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**

□ Lab Reports	□ Care Plan	□ Medication Record
□ Radiology Reports	□ Hospital/Operative Reports	□ History & Physical
□ Pathology Reports	□ Progress Notes	□ 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.

□ HIV/AIDS	□ Drug Abuse	□ Genetics
□ Sexually Transmitted Diseases	□ Psychotherapy Notes	□ Other (please state)
□ Mental Health	□ Alcoholism	_____

I authorize the following persons to make these disclosures of my health information: (PREVIOUS DOCTOR OR HOSPITAL)

Name:_____

Address:_____

Phone:_____

Fax:_____

I authorize the following persons to receive these disclosures of my health information:
PEDIATRICS AT DELMONT 5151 PLANK RD STE 310 BATON ROUGE, LA 70805

(P) 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:_____