AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Instructions: Fill in the appropriate information in each applicable section. Sign, Date, and return the form. Incomplete forms will not be processed. A separate authorization must be completed for each request.

I understand the information in the record of:

Name:_____ **DOB:**_____ **Phone Number:**_____

Address: _____

is personal and private, however I authorize:

Pediatric Clinic of St Mary Parish
1055 David Drive
Morgan City, LA 70380
Ph: (985)384-2430, Fax: (985)384-2473
medicalrecords@thepediatricclinic.org

To Release Information to/Receive Information from:

_____
Name of Doctor/Clinic and/or Organization

_____
Address **City** **State** **Zip Code**

Phone: _____ **Fax:** _____

The following specific information:
□ Specific Date(s) of Treatment_____
□ Immunization Record
□ All Records
□ Other _____

Medical records or the above listed information is to be released for the specific purposes of:
□ Changing physician/Further medical care
□ Other: _____

Patient Consent and Authorization to Release Medical Records:

- This authorization is valid for ninety (90)days from date signed. I understand this consent can be revoked by me in writing anytime before disclosure has occurred.
- Unless specifically excluded, this authorization includes release of specially protected records – such as referrals to, diagnosis of, and/or treatment for all health conditions.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by federal and state privacy laws and regulations.

The undersigned certifies that he/she is the parent/guardian the person listed above and has the legal authorization to sign on behalf of the person, whether by court order, or by operation of law. I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantages of disclosing such information. I hereby release above facility from all legal liabilities that may result from the release of the information according to this request.

Parent or Authorized Representative Signature:_____ Date:_____

Relationship to Patient:_____

FOR OFFICE USE ONLY
Date Request FAXED _____/_____/_____ **Date Medical Records RECEIVED** _____/_____/_____