

Associates in Pediatric and Adolescent Medicine
8040 Goodwood Boulevard
Baton Rouge, LA 70806
(225) 928-0867 (225) 928-1948 fax

Consent for Secure/Release of Information

Name: _____ Date of Birth: _____

Address: _____

I/We hereby authorize and request Associates in Pediatric and Adolescent Medicine to secure and/or release medical, laboratory, diagnostic, and other clinical information regarding the patient named above. I/We understand that this authorization may be revoked in writing at any time. Otherwise this consent automatically expires two years from the date of signature.

Signature: _____ Date: _____

Relationship (if person named above is a minor): _____

Witness signature: _____

This authorization applies only to the individuals/institutions: If not completed, no information will be released from our office (with the exception of the insurance and attending healthcare physicians).

Name: _____

Address/phone: _____

Name: _____

Address/phone: _____

Name: _____

Address/phone: _____

Name: _____

Address/phone: _____

I hereby further direct that a copy of this authorization shall be deemed to be as valid as the original for all purposed authorized herein.