Associates in Pediatric & Adolescent Medicine

Authorization for Release of Information

Please make sure all blanks are filled in; failure to do so may prevent or delay release of information. I hereby authorize you to release medical records for:

Patient Information

Name: _____

Address: _____

_____ Ph. # _____

DOB: _____ Maiden/Previous Name: _____

Provider
(What physicians or facility will be releasing information?)

Name: _____

Address: _____

_____ Phone: _____

Provide information To:
(Where is the information being sent?)

Associates in Pediatric & Adolescent Medicine

8040 Goodwood Blvd.
Baton Rouge, LA 70806
Ph. (225) 928-0867 Fax (225) 928-1948

Information Requested or to be Viewed

_____ Office Visit Progress Notes (date) _____
_____ Lab Data
_____ History and Physical (date) _____
_____ Discharge Summary (date)_____
_____ Immunization Records
_____ Other: _____

Comments: _____

_____

Disclosure:

I understand that this authorization may be revoked in writing by me at any time and that it will automatically expire 180 days after the date of signature. I understand that the recipient of this information may not use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signature of patient or Legal Representative: _____ Date: _____

Relationship if Not signed by Patient: _____