Authorization for Release of Medical Information

Patient Name: _____
DOB: _____

I, _____, hereby authorize the release of medical information **TO**:

La Petite Pediatric Clinic
200 Beaullieu Dr., Bldg 7
Lafayette, LA 70508
337.366.8616 (office) 337.366.8133 (fax)

FROM:
Doctor/Clinic/Hospital:_____

Address: _____

_____

Telephone: _____ Fax : _____

Please release the following:

___ **All health information (including growth charts and vaccination records)**
___ History/Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___ Other (specify): _____
___ Diagnostic Test Reports
___ Radiology/Images
___ Lab Results
___ Pathology Reports

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases, and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

___ Yes, I consent to the release of this information.
___ No, I do not consent to the release of this information.

Purpose of disclosure:
___ Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient:_____