YOUNGSVILLE PEDIATRICS

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Youngsville, LA 70592

Phone 337-857-5096
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AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

(including paper, oral, and electronic information)

PATIENT NAME _____ REQUEST DATE ____/____/____

MAILING ADDRESS _____ DATE OF BIRTH ____/____/____

CITY, STATE, ZIP _____ SSN _____

I AUTHORIZE:

PREVIOUS DR. NAME _____ TELEPHONE NO _____

MAILING ADDRESS _____ FAX NO _____

CITY, STATE, ZIP _____

RELEASE INFORMATION TO: SARAH U. LAURENTE, M.D., F.A.A.P.

THE PURPOSE OF THIS AUTHORIZATION IS INDICATED IN THE CIRCLE BELOW:

O FURTHER MEDICAL CARE

O CREATING HEALTH INFORMATION FOR DISCLOSURE TO A THIRD PARTY

O CHANGING PHYSICIANS

O OTHER _____

_____

I AUTHORIZE THE RELEASE OF THE FOLLOWING PROTECTED HEALTH INFORMATION:

O ENTIRE RECORD
O PRESCRIPTION RECORDS
O XRAY/CT/MRI REPORTS
O OTHERS _____

O MEDICAL HISTORY
O IMMUNIZATIONS
O SURGICAL REPORTS

O TREATMENT OR TESTS
O LABS
O GROWTH CHARTS

IN COMPLIANCE WITH STATE AND/OR FEDERAL LAWS WHICH REQUIRE SPECIAL PERMISSION TO RELEASE OTHERWISE PRIVILEGED INFORMATION, PLEASE RELEASE THE FOLLOWING:

O MENTAL HEALTH
O ALCOHOLISM
O VOCATIONAL REHAB

O STDS
O GENETICS
O PSYCHOTHERAPY NOTES

O DRUG ABUSE
O HIV (AIDS)

THIS AUTHORIZATION WILL EXPIRE SIX MONTHS FROM THE DATE ON WHICH THIS FORM WAS SIGNED.

NAME _____ RELATIONSHIP TO PATIENT _____

SIGNATURE _____ DATE ____/____/____