The Pediatric Center

Authorization to Release or Obtain Health Information

Patient _____ Date of Birth _____ Request Date _____

Address :_____

Street *City* *State* *Zip*

I authorize: The Pediatric Center of Southwest Louisiana

To Release Information **To** or **To Obtain** Information **From**

Name: _____

Address :_____

Street *City* *State* *Zip*

Phone: (_____)_____ Fax: (_____)_____

I authorize the release of the following protected health information:

Please Circle all that apply

Immunization Record Diagnostic Report Specialist Report Growth Charts Other _____

The Purpose of this Authorization is indicated below:

Please Circle

Further Medical Care Changing Physicians Legal Investigation or Action Personal

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I understand that this authorization will expire six (6) months from the date on which it was signed. All rights in regard to this authorization have been reviewed in the HIPAA Privacy Notice of the Pediatric Center of Southwest Louisiana.

_____ _____

Signature of Personal Representative authorized by law Date

If your child has special needs or sees a specialist on a regular basis, please fill out a form for each provider.

2640 Country Club Rd. Ste. 100
Lake Charles, La.70665
ph:337.477.0935 fax:337-528-2034

600 Cypress St.
Sulphur, La. 70663
ph:337.527.6371 fax:337-528-2034

340 N. Highway 171 Ste. B
Moss Bluff, La. 70611
ph:337.477.0935 fax:337-528-2034