



600 Cypress Street
Sulphur, La. 70663
(337) 527-6371 Phone
(337) 528-2034 Fax

Patient Name: _____

Date of Birth: _____

Address: _____

Parent E-Mail: _____

I Authorize: The Pediatric Center of Southwest Louisiana
600 Cypress Street
Sulphur, La. 70663-5052

To **RECEIVE** information **From**

Name: _____

Mailing Address: _____

Phone: _____ Fax: _____

E-Mail: _____

I Authorize the release of the following protected health information:

Summary of Care Immunization Record Diagnostic Reports Specialist Reports
 Growth Charts Other _____

The Purpose of this Authorization is indicated below (Please choose ONE).

Further Medical Care Changing Physicians Legal Investigation or Action Personal

I understand that this authorization will expire one (1) Year from the date on which it was signed. All rights regarding this authorization have been reviewed in the HIPAA Privacy Notices of The Pediatric Center of Southwest Louisiana.

Name of Personal Representative authorized by law

Relationship to Patient

Signature of Personal Representative authorized by law

Today's Date