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 **RELEASE** information **To**

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