Authorization to Release Protected Health Information to **The Pediatric Place, LLC**

18135 E. Petroleum Dr., Suite A
Baton Rouge, LA 70809
Tel (225) 636-5437
Fax (225)636-5547

Patient (Last, First, MI): ____ Gender: ☐ F ☐ M

Date Of Birth _____/_____/_____ Social Security #: _______________ Home Phone: (_____) ____________

Patient Address: ____

City: ____ State: ______ Zip: ____________

Authorization to Release Protected Health Information
I hereby authorize the following organization to release the information identified in this authorization form:

Medical Facility: _____________________________ Phone _______________ Fax ______________

Address: ____

City: ____ State: _____ Zip: ______________

Please send to: ☐ **Dr. Barrient** ☐ **Dr. Busenlener** ☐ **Dr. Philippe**

The Pediatric Place, LLC, 18135 East Petroleum Drive, Suite A, Baton Rouge, LA 70809
Fax# 225-636-5547

Information to be Released – Covering the Periods of Health Care

From Date: _____/_____/_____ Through Date _____/_____/_____

Please Indicate the Information to be Released Below:

☐ Complete Health Record ☐ Immunization Records

☐ Other (Please Specify) ____

Purpose of the Requested Disclosure of Protected Health Information:
I am authorizing the release of my Protected Health Information for the following purpose(s):

☐ Transfer of Medical Care ☐ Other ____

Right to Revoke Authorization:
Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to The Pediatric Place, LLC ATTN: Medical Records Manager at 18135 E. Petroleum Drive, Suite A, Baton Rouge, LA 70809. Unless revoked, this authorization will expire 6 months from the date of this release.

Re-disclosure
I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form.

Signature: ____ Date: ____/____/____

Printed Name: ____________________________ Relationship to patient: ______________________