Lafayette Pediatrics
JUDICE, BOUSTANY, GRANT & CLARK

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Authorization for Release of Records

Patient Name:_____ **Date of Birth:**_____

Patient Address:_____ **Chart #:**_____

_____ **Phone #:** _____

For Record Release or Copies: By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me/my child.

This authorization permits:

_____ **to use or disclose to** _____
Provider's Name **New Provider, Specialist, or Person Receiving Copy**

_____ _____
Street Address **Street Address**

_____ _____
City, State, Zip **City, State, Zip**

Information to be Released/Copied: ( ) All pertinent medical records including immunizations & lab
( ) Day sheets – dates:_____ **( ) Lab Info- dates:**_____
( ) Other:_____

Information to be Excluded/Not Release:_____
Reason for Record Release or Copy: ( ) Personal Copy ( ) Over age 18 ( ) Moving

( ) Insurance Change (please state insurance)_____ **( ) Referral to Specialist)**
( ) Unhappy with Practice (Please state why)_____
( ) Other:_____

_____ _____
Signature of Patient or Legal Guardian **Date**

_____
Print Name of Patient or Legal Guardian