AUTHORIZATION TO RELEASE HEALTH INFORMATION

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Phone 337-989-2322 Fax 337-981-0183

Patient Name:____ D.O.B.______________

Chart #: ____Phone #:_________________

I authorize the office of Lafayette Pediatrics to disclose my health care information.
Health Information related to the patient to be released under this authorization:

_ X_ Immunizations

TO:

____ Fax #________________________

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Patient Rights:
I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, enrollment, or elgibility). However, I do have to sign an authorization form to take part in a research study or to receive healthcare when the purpose is to create health information for a third party.

I may revoke this authorization in writing by sending a letter to the health care provider to whom the authorization is directed. If I did, it would not affect any actions already taken by the health care provider based upon this authorization.

I may not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that once the healthcare provider discloses my health information, the person or entity that receives it, may re-disclose it. The HIPAA Privacy laws may no longer protect it.

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Signature of Legal Guardian Date

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Print Name of Legal Guardian