

Patient Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Phone number:

I authorize:

Name: Legacy Pediatrics Mailing Address 107 Contempo Ave. Ste. A

City/State/Zip: West Monroe, LA 71291 Phone #: 318-324-0111 Fax#: 318-324-9679

To Release information TO or To Obtain Information FROM
(Place an "X" in the box that indicates if the information is being released OR requested.)

Previous physician: _____ Mailing address: _____

Phone: _____ Fax: _____

City, State, ZIP: _____

Relationship of person authorizing: _____

The Purpose of this Authorization is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

Transfer of care

Other: *(Specify)* _____

I authorize the release of the following protected health information.

(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

Entire Record Medical History, Exams, Reports Surgical Reports Treatment or tests Prescriptions
 Immunizations Hospital Records Lab Reports X-ray Reports MR/DD Reports Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

Alcoholism Drug Abuse Mental Health Vocational Rehabilitation HIV (AIDS) Genetics
 Sexually transmitted diseases Other: _____

This authorization shall expire on _____ (date or event) and is needed for the period

beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read this form.

Signature of individual or Personal Representative Authorized by Law

Date

Signature of Witness (If signed with an "X" or mark)

Date