Authorization for Release of Protected Health Information

I. Patient's Name:____ Birth Date:_________________________________

Patient's Address:____ Home Phone: ____________________________

City, State, Zip: ____

II. Records released to: ____

Mailing Address: ____ Phone Number: ___________________________

City, State, Zip: ____ Fax Number: ______________________________

Email: ____

III. Records released from: __North Oaks Pediatric Clinic, LLP____

Mailing Address: ___42440 Pelican Professional Park_________________ Phone Number: __(985) 542-4950__________

City, State, Zip: ___Hammond, LA 70403___________________________ Fax Number: ___(985) 318-6402__________

IV. Purpose of disclosure:

( ) Application for Insurance
( ) Processing of Insurance Claim
( ) Changing Doctors
( ) Legal - Custody
( ) Legal - Lawsuit
( ) Moving
( ) Other (Specify): ____

V. Check the records to be disclosed:

( ) Complete Records
( ) History and Physical
( ) Pathology Reports
( ) Consultations
( ) Laboratory Reports
( ) Physician's Progress Notes
( ) Diagnosis
( ) Nursing Notes
( ) Radiology Reports
( ) Discharge Summary
( ) Operative Reports
( ) Other (Specify): ____

( ) *I hereby acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, AIDS information, or genetic information, which may have specific statutory protection.*

For Treatment dates: ___________________________________ to ____

This authorization will expire on __________________. If I fail to specify a date or event, this authorization will expire **one year** from the date on which it was signed.

- Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
- A photocopy or fax of this authorization is as valid as this original.
- I may revoke this authorization at any time, except where information has already been released. This authorization is valid for one year period from the date it is signed, or sooner if noted above. The revocation must be in writing. A revocation form is available from the Medical Records department.
- North Oaks Pediatric Clinic, L.L.P., it's employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.
- This completed form authorizes North Oaks Pediatric Clinic ("NOPC") to disclose a patient's protected health information to a third party.
- NOPC reserves the right to verify my identity/guardianship.

____ ____

Patient/Legal Guardian **Relationship to Patient (if other than self)**

__XXX-XX-____________________________________ ____

Social Security Number (Last 4 for Identification Purposes Only) **Date**