Premier Pediatrics of Louisiana
325 W. 8th Street • DeRidder, LA 70634
Phone (337) 221-3075 • Fax (337) 221-3076
www.premierpediatricsla.net

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **DOB:** _____ **Phone #:** _____

Address: _____ **City, State, Zip:** _____

PLEAS **OBTAIN** INFORMATION **FROM:**	PLEASE **SEND** INFORMATION **TO:**
	Premier Pediatrics of Louisiana
Name of Provider/Clinic/Organization	*Name of Provider/Clinic/Organization*
	325 W. 8th Street
Street Address	*Street Address*
	DeRidder, LA 70634
City, *State, Zip*	*City, State, Zip*
Phone *Fax*	**337-221-3075** **337-221-3076**
	Phone *Fax*

I AUTHORIZE the ***FULL MEDICAL RECORD*** to be disclosed.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

EXPIRATION of this Authorization: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. *Unless otherwise revoked, this authorization will expire in one year.*

ADDITIONAL PATIENT INFORMATION: If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. 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.

_____ _____

Patient or Parent/Guardian Signature **Relationship to Patient**

_____ _____

Name of Patient or Parent/Guardian **Date**