Authorization for Release of Medical Record Information

PLEASE USE BLACK INK

If any section of this form is incomplete, form may be invalid.

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

Address: _____ **City/State/Zip:** _____

Phone number: _____

I hereby authorize:

The release of information TO:

☐ **LeBlanc Pediatrics**
1305 W. Causeway Approach
Mandeville, LA 70471
Phone: (985)674-2227
Fax: (985)674-1227

☐ **FROM** (Previous practice or Doctor's name)
Name: _____
Address: _____
City/State/Zip: _____
Phone #: _____
Fax #: _____

The release of information FROM:

☐ **LeBlanc Pediatrics**
1305 W. Causeway Approach
Mandeville, LA 70471
Phone: (985)674-2227
Fax: (985)674-1227

☐ **RELEASE TO**:
Name: _____
Address: _____
City/State/Zip: _____
Phone #: _____
Fax #: _____

The information is needed for the following reason:

- ☐ Transferring to another pediatric practice
- ☐ Transferring to an adult practice
- ☐ Personal use
- ☐ Attorney use
- ☐ Visit to a Specialist
- ☐ Other:_____

Type of information being released:

- ☐ Growth chart
- ☐ Immunization record
- ☐ Progress notes
- ☐ Labs/radiology
- ☐ Entire chart
- ☐ Other:_____

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a one (1) year period from the date it is signed.

By:_____ **Current date:** _____
Parent or legal guardian (if minor children)

Witness: _____ **Date:** _____