Authorization for Release of Medical Information

_____ _____

Patient Name **Date of Birth**

_____ _____

Address **City, ST, Zip** **Phone Number**

Date of Records Request: _____

I, the undersigned, authorize/request the below named medical office/physician to release my medical records.

_____

Name of Physician/Office/Clinic/Hospital

_____ _____

Address **Office Phone Number**

_____ _____

City, ST, Zip **Office Fax Number**

Please release my medical records to the following:

Olabode Desalu, MD **Amanda Kampert, MD**

Choice Pediatrics
6930 Fern Ave, Suite 150
Shreveport, LA 71105
(318) 290-3673 Fax (318) 290-3672

My request for this particular release of medical records includes the following:
(Please initial appropriate line below)

____All healthcare information INCLUDING information relating to HIV/AIDS, STDs Psychiatric Disorders or Drug/Alcohol Abuse

____All healthcare information EXCLUDING information relating to HIV/AIDS, STDs, Psychiatric Disorders or Drug/Alcohol Abuse

The Facility and its doctors are hereby released and discharged from any liability and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

_____ _____

Patient or Authorized Representative Signature **Date**

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: *This information has been disclosed to you from records whose confidentiality is protected. Statutes and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.*