Southern Sprouts
PEDIATRICS

AMANDA COLE, APRN, CPNP-AC/PC
HEATHER RACHAL, APRN, CPNP-AC/PC

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient's Name _____ Date of Birth _____

MEDICAL INFORMATION TO BE RELEASED BY

_____
Practice/Provider Name

_____ _____
Office Number Fax Number

I authorize the release of the following medical information

☐ Complete Medical Record ☐ Diagnostic Imagining ☐ Laboratory/Pathology Reports ☐ Hospital Records
☐ Immunizations ☐ Medical History, Consultation/Evaluation Records ☐ Other _____

Reason for request

☐ Changing Physicians ☐ Personal ☐ Continuing Medical Care ☐ Other (Specify) _____

MEDICAL INFORMATION TO BE RELEASED TO

Southern Sprouts Pediatrics
Attention: Medical Records
P.O. Box 13211
Alexandria, Louisiana 71315

I hereby consent to the release of the specified information relating to diagnosis, testing, or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named organization. I understand that I have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

_____ _____
Patient or Representative's Signature Printed Name

_____ _____
Relationship to Patient Date