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

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Provider/Facility Name: _____ Address: _____
City: _____ Zip Code: _ _ _ _ _ Phone: _ _ _ - _ _ _ - _ _ _ _ Fax: _ _ _ - _ _ _ - _ _ _ _

I, the parent/guardian of the child listed above, hereby authorize the release and disclosure of the patient's protected health information, as described below, to Mitchells Pediatrics for the purpose of continuation of care.

- ☐ All records including growth charts and immunizations
- ☐ Newborn records
- ☐ ER/Hospital/Urgent Care records
- ☐ Laboratory results
- ☐ Imaging reports
- ☐ Operative reports
- ☐ Other, _____

Requested medical records should be faxed or mailed to:
Mitchells Pediatrics
221 Pecan Park Avenue
Alexandria, LA 71303
Phone: 318-487-1602 | Fax: 1-877-526-9271

- This medical information may be disclosed to and used by the individual or entity I have authorized for purposes including, but not limited to, medical treatment, consultation, billing, claims payment, or other purposes as specifically directed by me. This authorization shall remain valid for one (1) year from the date of signature unless revoked earlier in writing by the patient or the patient's legal representative.
- This authorization applies to information relating to all past, present, and future periods of care unless otherwise limited herein.
- I understand that I have the right to revoke this authorization at any time by providing written notice. I further understand that such revocation will not apply to actions already taken in reliance on this authorization, nor to circumstances in which this authorization was obtained as a condition of insurance coverage and the insurer has a legal right to contest a claim under the policy.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon my signing of this authorization.
- I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by applicable federal or state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

Parent/Guardian Name: _____ Relationship to patient: _____ Phone: _ _ _ - _ _ _ - _ _ _ _

Parent/Guardian Signature: _____ **Date:** _ _ / _ _ / _ _ _ _

Staff Signature: _____ | Date: _ _ / _ _ / _ _ _ _ | Time: _ _ : _ _ am/pm