Magnolia Pediatrics

17038 Commerce Centre Drive, Prairieville, LA 70769
Phone: 225.744.4484 Fax: 225.677.9359

Authorization for Disclosure of Health Information

Please mail records to the address above. PLEASE DO NOT FAX UNLESS REQUESTED

Patient Name: ______________________________ Date of Birth: __________ M/F: _____

Address: ____

City: ____________________ State: ______ Zip: _______ Phone: (_____) - ______- ________

I authorize the use or disclosure of the above named individual's health information as described below.
The following individual(s) or organization(s) are authorized to make the disclosure:

Previous Primary Care Physician: ____________________ Name of Practice: ____________________

Address: ____________________________City: __________________ State: _____Zip: _______

Phone: (_____) - ______- ________ Fax: (_____) - ______- ________

Purpose of disclosure:
X Complete Health Record X Immunization Records

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.

This information may be disclosed to and used by the following individual or organization:
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I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. 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 on the following date, event, or condition:

If I fail to specify an expiration date, event, or condition, this authorization will expire I sixty (60) days. 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, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about this disclosure of my health information, I can contact:
Lisa Hamner
Privacy Officer for Magnolia Pediatrics

______________________________ ______________________
Signature of patient or legal representative Date

______________________________ ______________________
Printed Name Relationship to patient