PEDIATRIC CLINIC
SAINT FRANCISVILLE

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# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

Mother's Name: _____ Mother's Date of Birth: _____

I request and authorize _____
to release healthcare information of the patient named above to:

Patricia M. Schneider, MD Pediatric Clinic
*Patricia M. Schneider, MD, FAAP*
*Kelli D. David, APRN, CPNP*
*Kathryn N. Jewell, APRN, FNP-C*

West Feliciana Parish Hospital Pediatric Clinic
*E. Brooke Bock, MD, FAAP*

This request and authorization applies to the following protected health information:

□ Entire Medical Record □ Medical History, Examination, Reports □ Birth Screens □ Surgical Reports
□ Birth Records □ Immunizations □ Hospital Records including Reports □ Laboratory Reports
□ Radiology Reports □ Other _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records checked below:

□ Mental Health □ Vocational Rehab □ HIV (AIDS) □ STDs □ Genetics □ Psychotherapy Notes
□ Other _____

I understand that:

- Future disclosures regarding these records may be made to the same individual or entity described in this consent until it expires.
- I can revoke part or all of this authorization at any time by notifying the above-named facility/provider except for information that may have been disclosed before my revocation.
- A refusal or revocation to release information may result in improper diagnosis, treatment, denial of insurance coverage, or other adverse consequences.
- I can review my medical records and refuse to disclose some or all of the information in them.
- I may have a copy of this document upon request.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian (If Minor): _____ Date: _____

Witness: _____ Date: _____