



Jennifer Midgett, LLC / Premier Pediatrics of Louisiana

325 W. 8th St., Deridder, LA 70634

Tel: 337-221-3075 Fax: 337-221-3076

www.premierpediatricsla.net

MEDICAL RECORD REQUEST & AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ DOB: _____ Phone #: _____

Address: _____ City, State, Zip: _____

PLEASE OBTAIN INFORMATION FROM:

PLEASE SEND INFORMATION TO:

Name of Provider / Clinic / Organization

Premier Pediatrics of Louisiana

Name of Provider / Clinic / Organization

Street Address

325 W. 8th Street

Street Address

City, State, Zip

DeRidder, LA 70634

City, State, Zip

Phone

Fax

337-221-3075

Phone

337-221-3076

Fax

I AUTHORIZE the FULL MEDICAL RECORD to be disclosed.

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.

EXPIRATION of this Authorization: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. 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 in one year.

ADDITIONAL PATIENT INFORMATION: If I fail to specify an expiration date, event or condition, this authorization will expire in one year. 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. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Patient or Parent/Guardian Signature

Relationship to Patient

Name of Patient or Parent/Guardian

Date