Mansoor Pediatrics

Avoyelles Pediatrics Healthy Steps Pediatrics Pediatrics on the Red

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:

_____Immunization Record _____Lab Reports _____Diagnostic Imagining

_____Complete Medical Records _____Hospital Records

MEDICAL INFORMATION TO BE RELEASED TO:

Mansoor Pediatrics

2226 Worley Drive Alexandria, LA 71301

Phone: 318.561.0003 Fax: 318.704.6015

My Rights:

- *I understand that I do not have to sign this authorization to get healthcare benefits (treatment, payment, enrollment, or eligibility). However, I do have to sign an additional authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.*
- *I may revoke this authorization in writing by sending a letter to the healthcare provider to whom the authorization is directed. If I did, it would not affect any actions already taken by the healthcare provider based upon this authorization.*
- *I may not be able to revoke this authorization if its purpose was to obtain insurance.*
- *I understand that once the healthcare provider discloses my health information, the person or entity that receives it, may re-disclose it. The HIPAA Privacy laws may no longer protect it.*

By signing below, I authorize the healthcare providers and/or facilities listed above to release medical records and health information as described above to Mansoor Pediatrics.

Patient/Parent/Guardian Signature _____ ***Printed Name*** _____

Relationship to Patient _____ ***Date*** _____

Staff Initials: _____ ***Date:*** _____ ***Faxed*** _____ ***Mailed*** _____

Records Received on: _____ ***Scanned in on:*** _____

HIPAA Compliant Medical Authorization [Pursuant to 45 C.F.R. sec. 164.508 (6)] Revised 07/01/2018