***Authorization for Release of Protected Health Information***

***This completed form authorizes a third party to disclose a patient's protected health information to   
DCS Pediatric and Family Health Clinic***

1. Patient's Name: Birth Date:

Patient's Address: Home Phone:

City, State, Zip:

1. Records released to:

Mailing Address: Phone Number:

City, State, Zip: Fax Number:

1. Records released from: DCS Pediatric and Family Health Clinic

Mailing Address: 19100 Dr. John Lambert Drive Phone Number: (985) 247-4567

City, State, Zip: Hammond, LA 70403 Fax Number: (985) 467-0896

1. Purpose of disclosure:

( ) Application for Insurance ( ) Processing of Insurance Claim ( ) Changing Doctors

( ) Legal -Custody ( ) Legal - Lawsuit ( ) Moving

( ) Other (Specify):

1. Check the records to be disclosed:

( ) Complete Records ( ) History and Physical ( ) Pathology Reports

( ) Consultations ( ) Laboratory Reports ( ) Physician's Progress Notes

( ) Diagnosis ( ) Nursing Notes ( ) Radiology Reports

( ) Discharge Summary ( ) Operative Reports

( ) Other (Specify):

*( ) I hereby acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, AIDS information, or genetic information, which may have specific statutory protection.*

**For Treatment dates: to**

This authorization will expire on . If I fail to specify *a* date or event, this authorization will expire one year

from the date on which it was signed.

* Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
* A photocopy or fax of this authorization is as valid as this original.
* I may revoke this authorization at any time, except where information has already been released. This authorization is valid for one year period from the date it is signed, or sooner if noted above. The revocation must be in writing. A revocation form is available from the Medical Records department.
* DCS Pediatric and Family Clinic**,** its employees, and providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
* Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
* Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.
* DCS reserves the right to verify my identity/guardianship.

**Patient/Legal Guardian Relationship to Patient (if other than self)**

**Social Security Number (Last 4 for Identification Purposes Only) Date**

**Revised April 1, 2021**