Pediatric Associates of Denham Springs, LLC Consent to Release Information

Patient Name:			Date of Birth:
Address:			
Address:Parent Name:			Phone:
*			1)
T Austhanian	W W		
I Authorize: Pediatric Associates of Der	shaw Carinas / Dr. Puia	y F Zagyiar	
1211 North Range Avenue,		a E. Zgunjur	
Denham Springs, LA 70726	S Phone	: 225-665-6677	Fax: 225-665-0055
D 011114111 Dp 111601, 211 1 1 1 1			
To obtain information	from:		¥
To obtain information from: (Please give the name, address and phone number of past doctors, hospitals, etc.)			
(Flease give the name, address and phone number of past doctors, nospitals, etc.)			
₹			
Or:			
		÷ s	
To Release information to:			
(New Doctor, Lawyer, Parent, School, Daycare, etc.)			
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The Purpose of this request is: (Circle Below)			
The state of the s	1	· · · · · ·	
Further Medical Care	Personal	Legal Invest	igation or Action
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Chanaina Dhessiaiana	Danaarah Da	lated Treatmen	ts Other
Changing Physicians Research Related Treatments Other			
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I authorize the release of the following protected health information: (Circle Below)			
			* * * *
Entire Record	Medical History	Treatment N	fotes
c t			
Prescriptions	Immunizations	Laboratory/2	X-Ray Reports
Newborn Metabolic Screening Labs			
	,		
This Authorization shall expire on (Date or Event)			
I understand that if I do not specify an expiration date, this authorization will expire one			
(1) year from the date on which it was signed.			
(1) your moin the date	on the state of the state	-370	*
Signature			Date