Pediatric Associates of Denham Springs, LLC
Consent to Release Information

Patient Name: _____ Date of Birth: _____
Address: _____
Parent Name: _____ Phone: _____

I Authorize:
Pediatric Associates of Denham Springs / Dr. Brian E. Zganjar
1211 North Range Avenue, Suite D
Denham Springs, LA 70726 *Phone: 225-665-6677* *Fax: 225-665-0055*

To obtain information from: _____
(Please give the name, address and phone number of past doctors, hospitals, etc.)

Or:

To Release information to: _____
(New Doctor, Lawyer, Parent, School, Daycare, etc.)

The Purpose of this request is: (Circle Below)

Further Medical Care Personal Legal Investigation or Action

Changing Physicians Research Related Treatments Other _____

I authorize the release of the following protected health information: (Circle Below)

Entire Record Medical History Treatment Notes

Prescriptions Immunizations Laboratory/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.

Signature _____ Date _____