919 S. 10th Street
Leesville, LA 71446

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Date: ___________________

Please complete the following information:
Patient(s) Name: ______________________________ DOB:_________________
______________________________ DOB:_________________
______________________________ DOB:_________________

I, _________________________, hereby authorize ________________________ to

disclose/release the following information* to _______________________________.

*Please check all applicable:

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Billing records
- ☐ Abstract/Summary
- ☐ Pharmacy/prescription records
- ☐ Other (describe specifically)____________

Note: *If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

_________________________________ _____________
Signature of Parent/Guardian *Date*

_________________________________ _____________
Witness *Date*