Pediatric Associates of Lafayette, P.C.

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RECORDS RELEASE AUTHORIZATION

PLEASE FILL OUT THE FORM COMPLETELY

Patient Name _____ Date: _____

Date of Birth _____ Phone# (____) ____-_____

Address _____

City _____ State _____ Zip _____

RELEASE TO:

_____
Name of facility/physician

_____
Address

_____
City, State, Zip Code

RELEASE FROM:

Pediatric Associates of Lafayette, P.C.
2300 Ferry St.
Lafayette, IN 47904

INFORMATION TO BE RELEASED:

❖ ALL RECORDS

THE PURPOSE FOR DISCLOSURE

- ○ Transfer due to age
- ○ Found care closer to home
- ○ Moving
- ○ Insurance Change
- ○ Personal Use - Fee Will Apply
- ○ Other

I, the undersigned, understand that I may revoke this authorization at any time, in writing, but the request shall remain valid until revoked or upon the expiration of (60) days, whichever occurs first, except to the extent that action has been taken thereon. I understand that I am giving permission to release medical information which may include treatment for physical and/or emotional illness, pregnancy, genetic testing, communicable diseases, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS-related information. I further understand that my protected health information that is used or disclosed under the Authorization may be subject to re-disclosure and no longer protected by the law.

PATIENT/CONSENTING PARTY: _____
Printed Name

Signature: _____
Guardian if Patient is under 18

_____
Current Address

_____
City, State, Zip Code

Medical records are legal documents, therefore owned by the provider. Charges for copies of these documents may apply.