LOUISIANA
CHILD NEUROLOGY

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

Please complete the following information:
Patient Name: _____
Address: _____
Phone: _____
SSN: _____
Date of Birth: _____

I authorize the custodian of records of _____(hospital/clinic name) to disclose/release the following information* (check all applicable):

☒ All Neurology records (typed and handwritten clinic notes)
☒ Laboratory/pathology records
☒ X-ray/radiology records
☒ 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.*

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional sheets if necessary):

Name: Louisiana Child Neurology, LLC
Address: 190 Greenbrier Boulevard, Suite 105, Covington, LA 70433
Phone: 985-327-5880
Fax: 1-866-676-2280

The information may be used/disclosed for each of the following purposes:

☐ At my request (only the patient can check)
☒ For my health care
☐ For payment/insurance
☐ Other: _____

This authorization shall expire no later than one year from the date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ Signature of patient (or patient's personal representative)

_____ Date

_____ Printed name of patient representative

_____ Representative's authority to sign for patient, *(i.e* parent, guardian, power of attorney for healthcare, executor)

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to Louisiana Child Neurology, LLC. A copy of this signed authorization must be given to the individual.