CHILDREN'S CLINIC OF RACELAND

110 Acadia Drive, Raceland, LA 70394 ■ Phone: (985)537-8687 ■ Fax: (985)537-8976

AUTHORIZATION TO RELEASE MEDICAL RECORDS

_____ _____

Patient Name: Date of Birth

I hereby authorize the release of the following medical records:

Please check appropriate Box: ☐ To ☐ From

Children's Clinic of Raceland
110 Acadia Drive
Raceland, LA 70394
Phone: (985) 537-8687
Fax: (985) 537-8976

Record to be requested: ☐ To ☐ From

Clinic/Physician: _____
Address: _____
City: _____State: _____Zip Code_____
Phone: _____ Fax: _____

My authorization extends to the date elements/documents listed below:

_____All Medical Records
_____Immunization Record
_____Other: _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except otherwise provided by law. A Photocopy or fax of this authorization is valid as the original.
2. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for one year from the date it is signed, or sooner if noted below.
3. Children's Clinic of Raceland, employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the information to the extent indicated and authorized herein.

_____ _____

Signature (Parent/Guardian) Relationship

_____ _____

Printed Name Date