Mid City Pediatrics
2225 Line Ave
Shreveport, La 71104
Phone: 318-221-2225
Fax: 318-459-2955

Patient Name: _____ Date of Birth: _____

Previous Name:_____

Authorization for _____ to disclose my health care information.
(Name of physician or title of organization)

_____
Address

_____
City State Zip

You may disclose this information to: _____
(Name of physician or title of organization) Phone number

_____
Address

_____
City State Zip

_____ At my request

_____ Other: _____

This authorization ends on _____ or when the following event occurs:_____.
Date

My Rights

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing by sending a letter to the health care provider to whom the authorization is directed. If I did, it would not affect any actions already taken by the health care provider based upon this authorization.

I may not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that once the health care provider discloses my health information, the person or entity that receives it, may re-disclose it. The HIPAA Privacy laws may no longer protect it.

_____ _____
Signature Date

_____ _____
Address Relationship

_____ _____
City State Zip Phone number