2225 Line Avenue
Shreveport, Louisiana 71104
www.midcitypeds.com
Phone: 318-221-2225 Fax: 318-459-2955

Patient Name: _____ Date of Birth: _____

Previous Name: _____

Authorization for: _____ to disclose my healthcare information.

Address: _____ Phone: _____

City, State, Zip_____ Fax: _____

You may disclose this information to: _____

Address: _____ Phone: _____

City, State, Zip_____ Fax: _____

___ At my Request

___ Other: _____

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

**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 HIPPA Privacy laws may no longer protect it.

Signature _____ Date: _____

Address: _____ Relationship: _____

City, State, Zip_____ Phone: _____