Authorization for Release of Protected Health Information

This completed form authorizes a third party to disclose a patient's protected health information to North Oaks Pediatric Clinic ("NOPC")

I. Patient's Name:_____ Birth Date:_____

Patient's Address:_____ Home Phone: _____

City, State, Zip: _____

II. Records released to: _____

Mailing Address: _____ Phone Number: _____

City, State, Zip: _____ Fax Number: _____

III. Records released from: North Oaks Pediatric Clinic, LLP

Mailing Address: 42440 Pelican Professional Park Phone Number: (985) 542-4950

City, State, Zip: Hammond, LA 70403 Fax Number: (985) 318-6402

IV. Purpose of disclosure:

( ) Application for Insurance ( ) Processing of Insurance Claim ( ) Changing Doctors
( ) Legal - Custody ( ) Legal - Lawsuit ( ) Moving
( ) Other (Specify): _____

V. Check the records to be disclosed:

( ) Complete Records ( ) History and Physical ( ) Pathology Reports
( ) Consultations ( ) Laboratory Reports ( ) Physician's Progress Notes
( ) Diagnosis ( ) Nursing Notes ( ) Radiology Reports
( ) Discharge Summary ( ) Operative Reports
( ) Other (Specify): _____

( ) *I hereby acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, AIDS information, or genetic information, which may have specific statutory protection.*

For Treatment dates: _____ to _____

This authorization will expire on _____. If I fail to specify a date or event, this authorization will expire **one year** from the date on which it was signed.

- Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
- A photocopy or fax of this authorization is as valid as this original.
- I may revoke this authorization at any time, except where information has already been released. This authorization is valid for one year period from the date it is signed, or sooner if noted above. The revocation must be in writing. A revocation form is available from the Medical Records department.
- North Oaks Pediatric Clinic, L.L.P., it's employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.
- NOPC reserves the right to verify my identity/guardianship.

_____ _____
Patient/Legal Guardian **Relationship to Patient (if other than self)**

XXX-XX-_____ _____
Social Security Number (Last 4 for Identification Purposes Only) **Date**

NORTH OAKS
PEDIATRIC CLINIC, L.L.P.
42440 Pelican Professional Park
Hammond, Louisiana 70403
985-542-4950
After Hours Emergencies 985-345-2700
Fax 985-542-6089

LEO R. WESTMORELAND, JR., M.D.
ROGER D. RHOLDON, SR., M.D.
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SAM A. HICKEY, JR., M.D.
ELIZABETH H. FRITZ, M.D.

Dear Requester:

Please be advised that HealthPort has contracted with North Oaks Pediatric Clinic for the purpose of copying and releasing copies of the medical records that you have requested. As provided for in LA R.S. 40:1299.96, please be aware that there is a fee for providing this service as follows:

$1.00 per page for the first 25 pages
$.50 per page for 26-500 pages
$.25 per page for 501 + pages
Plus a possible handling charge

Records can be picked up from our office once ready. We will call you to let you know when they are done. An invoice will be mailed to you directly from HealthPort and all payments will go directly through HealthPort.

Thank You,
North Oaks Pediatric Clinic
Medical Records Department