Allison Hatfield, M.D.
Sarah Latiolais Ardoin, M.D.
Emily Fruge' Simon, M.D.
Allison Wilson, FNP

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Opelousas, La 70570
(337) 942- 4453 Phone
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Authorization to Release or Obtain Health Information

Name: _____ Date of Birth: _____ SSN#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Name of Insurance : _____ Parent DOB: (for ins purposes) _____

I authorize: Lily Pad Pediatrics □ **Release Information To OR** □ **Obtain Information From**

Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____

***PLEASE NOTE: We cannot accept any records on any portable storage device such as a CD or USB drive**

The **Purpose of this Authorization** is indicated below: (Please place a check in the box that applies)
__ Changing Physicians __ Legal Purposes __ Further Medical Care __ Other: _____

Preferred Provider: ___ Dr. Hatfield ___ Dr. Latiolais Ardoin ___ Dr. Simon ___Crystal Dupre', FNP ___Allison Wilson, FNP

Records to Include:
This authorization pertains to the disclosure of the record types indicated below between the following dates of service:
from _____ to _____ OR select one of the following options:
_____ All records retained by facility/office
_____ Progress notes _____ Hospital records _____ Laboratory notes _____ Immunization records
_____ Operative reports _____ Imaging reports _____ Other specified information: _____

Immunization Policy Agreement: I have read and agree to the Immunization Policy of Lily Pad Pediatrics. _____(initial)

Disclosure of Sensitive Information:
I understand that my health record may contain sensitive information relating to the patient's condition(s). This includes, but is not limited to, information pertaining to sexually transmitted disease, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), behavioral or mental health services and treatment for alcohol or drug abuse. By initialing this box, I choose to exclude the above types of information from this disclosure. _____ (initial)

Terms and conditions:
* I have the right to revoke this Authorization, in writing, at any time by notifying the Privacy Office and the health care provider being requested to disclose health information (if applicable). Such revocation will not apply to information that already had been disclosed in reliance on this Authorization.
* I have the right to not sign this Authorization. Lily Pad Pediatrics will not condition treatments, payment for services or enrollment or eligibility for benefits on whether I sign this Authorization.
* If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is the potential for this information to be subject to re-disclosure and no longer be protected by these laws.
* I have read and understand this Authorization, have had an opportunity to have my questions answered, have signed this Authorization freely and have received a copy of this Authorization.
* Please note, this Authorization expires one (1) year after the date of signature unless otherwise specified: _____.

I understand that the information to be released is considered confidential and is to be utilized by the recipient only for the purpose of medical treatment.

Signature: _____ Date: _____ Phone Number: _____

Printed Name: _____ Relationship: _____