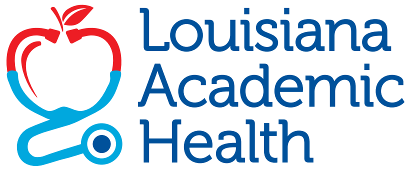

School Clinic Name:______________________________

School Term:____________________________________

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize **Louisiana Academic Health** to release confidential health information about myself or my child, by releasing a copy of medical records, or a summary or narrative of protected health information, to the physician/person/facility/entity listed below.

Patient Name:____ Date of Birth:____________________________

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name:____

Address:____

City, State, Zip Code:____

The purpose/reason for this release of information is as follows:

____

____

____ ____________________________________

Signature of Patient/Guardian Date