

## AUTHORIZATION FOR RELEASE OR TRANSFER OF MEDICAL RECORD

Patient's full name<sup>1</sup>: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (month / day / year)

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Daytime Phone #: (     ) \_\_\_\_\_  Cell #      Work #

Date of Authorization: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (month / day / year)

**I authorize a one-time release of my child's medical records to**

**Cypress Pediatrics  
200 W Esplanade Avenue, Suite 314  
Kenner, LA 70065**

PURPOSE FOR THIS REQUEST:      Transfer of Care

TYPE OF RECORDS REQUESTED:      Copy of the entire medical record, as allowed by law.

### Signature Section:

Requestor's Full Name:

\_\_\_\_\_

Requestor's Signature:

\_\_\_\_\_

By my signature I certify that I am the parent or legal guardian of the patient named here.

\_\_\_\_\_

<sup>1</sup> If more than one child in the family, please complete a separate form for each patient