AUTHORIZATION FOR RELEASE OR TRANSFER OF MEDICAL RECORD

Patient's full name[1]: _____

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.

[1] If more than one child in the family, please complete a separate form for each patient