Authorization for Release of Medical Records

Patient Name(s): _____ **DOB(s):**_____

_____ _____

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

_____ Complete record

_____ Records of care from _____ to _____ only

_____ Records of care concerning the following conditions _____

_____ Other. Specify: _____

HIV/AIDS/ other STDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.

Initial _____ Date _____

From: _____ Address: _____ Ph/Fax_____

To the following person(s):

Dr. Kelli M. Cocke, M.D.
Parkway Pediatrics, LLC
6800 Ambassador Caffery Pkwy
Broussard, LA 70518
337-330-4525 // 337-330-4526 (fax)

The reasons or purposes for this release of information are:

____ Physician Change

____ Second Opinion

____ Other: _____

Signed:_____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)

_____ _____ _____

Relationship to patient Witness Date

Please Fax or Mail the records promptly. Thank you for your cooperation.