

3525 Prytania Street, Suite 602 • New Orleans, LA 70115-8141 www.halespediatrics.com • Tax ID: 72-1022419 • Fax: (504) 897-6262 • Office: (504) 897-0744

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

The following document pertains to	D:					
Patient's Name	Date of Birth Phone Number					
Address		City		State	ZIP	
I authorize Hal	es Pediatrics, 3525 Pryta	ania Street	, Suite 602, New Orle	ans, LA 70115-814 ⁻	1	
	☐ to release to	OR	☐ to receive from			
Name of hospital/physician OR Na	ame of parent, guardian, or pa	tient over 18	3 years old			
Address		City		State	ZIP	
() Phone Number			((Fax Nu	mber		
for the purpose of:						
My authorization extends only to th	e PHI listed below <i>(please</i>	check all th	at apply):			
☐ Immunization Record*	☐ Growth Chart*	☐ P	rogress Notes: date	to		
☐ Laboratory/Imaging Reports	☐ Entire Record	\ 0	ther:			
*(Note: If Hales Pediatrics is releasi upon request. Additional rec \$1 per page for the first 25 p		atient will foll	low these guidelines:	record will be provide	ed to the parent/patien	
By signing this authorization, I am ag	reeing to the use and disclo	sure of this	patient's protected health	information.		
Signature of parent, guardian, or patien	t over 18 years old		Date signed	,		
Print Name			Relationship	to Patient		
FOR OFFICE USE ONLY:						
Date Received		Date	Completed			
Faxed / Mailed By		Pay	Payment Rec'd			