Children's Clinic of Southwest Louisiana, Inc.

2903 1st Avenue
Lake Charles, LA 70601
Phone: 337-478-6480
Fax: 337-478-6696
www.ccswla.com

RELEASE OF MEDICAL INFORMATION

Please complete the following information to facilitate identification of this record:

PATIENT NAME: _____ BIRTHDAY: _____

PATIENT NAME: _____ BIRTHDAY: _____

PATIENT NAME: _____ BIRTHDAY: _____

ADDRESS: _____

_____ TELEPHONE: _____

DATES OF MEDICAL RECORDS NEEDED: _____

☐ **CONSENT FOR THE RELEASE OF MEDICAL INFORMATION**

I authorize Children's Clinic of SWLA to release any information contained in my child's medical record to:

NAME: _____

ADDRESS: _____

I understand that this authorization unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV (AIDS virus) or other sexually transmitted diseases, substance abuse or mental health conditions.

I release the Clinic and its staff from all legal responsibility or liability that may arise from the release of this information. This consent may be revoked by me at any time, except when action has been taken. This release expires 60 days from the date below.

NAME AND RELATION TO PATIENT (print) _____

SIGNATURE _____ DATE _____

☐ **REQUEST FOR MEDICAL INFORMATION**

I authorize _____

ADDRESS: _____

to release any and all information contained in my child's medical records to
Children's Clinic of SWLA, 2903 1st Ave., Lake Charles, LA 70601.

I understand that this authorization unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV (AIDS virus) or other sexually transmitted diseases, substance abuse or mental health conditions.

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NAME AND RELATION TO PATIENT (print) _____

SIGNATURE _____ DATE _____