Parkway Pediatrics LLC

Authorization for Release of Medical Records

Patient's Name: _____ **DOB:** _____

This letter will authorize this office to provide a copy, summary, or narrative of my medical records as indicated by the check marks 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 results for AIDS or HIV infection, antibodies to AIDS, or other causative agent of AIDS, with the rest of my medical records. **Initial** **Date**

Previous Doctor: _____**Address:** _____

Phone: _____ **Fax:** _____

To the Following Person(s):

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

The reason or purpose for this release of information is:

_____ 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 medical records/immunization records promptly, Thank you for your cooperation.***