



**Willis-Knighton Health System**  
 2600 Greenwood Road  
 Shreveport, LA 71103

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

Printed Name of Patient \_\_\_\_\_

Previous Names, if applicable \_\_\_\_\_

Date of Birth \_\_\_\_\_

Daytime Telephone Number \_\_\_\_\_

**SEND INFORMATION TO: (please be specific)**

Provider Name/Organization: Portico Pediatrics

Address: 1717 E. Bert Kouns Industrial Loop  
Shreveport, LA 71105

Phone #: (318) 212-3930

Fax #: (318) 212-3958

**INFORMATION TO BE RELEASED FROM: (please be specific)**

Provider Name/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

**PURPOSE OF DISCLOSURE:**     Transfer of Care     Self     Specialist     Other \_\_\_\_\_ (must complete)

**INFORMATION TO BE DISCLOSED:**

- Medical Records from last two years
- Summary Health Information
- Complete Designated Record Set
- Other: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

**Expiration Date (or event)** \_\_\_\_\_

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by HIPAA of 1996. I acknowledge that I have received a copy of the Notice of Privacy practices. \_\_\_\_\_ (Initials)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Relationship to Patient

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

- HIV/AIDS Virus \_\_\_\_\_
- Sexually Transmitted Diseases \_\_\_\_\_
- Mental Health/Psychiatric Disorders \_\_\_\_\_
- Drug, Alcohol Abuse/Treatment \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Relationship to Patient

For Facility Use:		
Date Received: _____	Date Information Released: _____	Chart #: _____
Person /Department Sending Records: _____		



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