

Personal Pediatric Care of Picayune LLC
104 Street A
Picayune, MS 39466
(769) 242-0557

AUTHORIZATION TO RELEASE INFORMATION

1. Patient Identification:

Name: (Last, First, MI)		
Street Address:		
City:	State:	Zip Code:
Birth Date:	Phone Number:	

2. Information to be release: (check all that apply)

- ☐ Educational Records
- ☐ Discharge Summary (Inpatient dates: _____ to _____)
- ☐ Medication Record
- ☐ Other: _____

3. Purpose of this request: _____

4. Duration: This authorization shall become effective immediately and remain in effect until (date) _____.

5. My rights:

- I may revoke or change this authorization at any time in writing to Personal Pediatric Care of Picayune, LLC, except where a disclosure has already been made in reliance on my prior authorization.
- I have a right to receive a copy of this authorization.
- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- If the person or facility receiving this information is not covered by privacy regulation, the information stated above could be re-disclosed.

I have read and understand this information:

Signature: _____

Date: _____

Witness: _____

Date: _____