Tchefuncta
urgent care

614 W. 11th Ave.
Covington, LA 70433

Phone (985) 809-8868
Fax (985) 809-8838

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ Date of Birth _____
First name middle last name MM/DD/YYYY

Address: _____

_____

Phone # (____) _____

SS # _____ - ____ - _____

Hereby authorize/request you, _____

to release confidential information contained in my medical records, including but not limited to, progress notes, immunizations, history & physical, radiology reports, lab reports, ECG reports, discharge summaries, medication reports, and consultation reports.

I authorize no limits on dates, history of illness, or diagnostic and therapeutic information, including any dependency, HIV, AIDS and/or other communicable diseases._____
(Initials)

PHI released to: **Tchefuncta Urgent Care**

Patient _____

Guardian _____

PCP _____

Other _____

_____

_____

Date: _____ Patient's signature: _____