200 Liberty Avenue
Lafayette, LA 70508
PH: (337) 989-8080 FAX #: (337) 981-0913

MEDICAL/FINANCIAL INFORMATION DISCLOSURE

Patient Name: _____ Date of Birth: _____

Legal Guardian or Main Contact Person:
Name: _____ Phone #: _____
Relationship to Patient: _____ (home/work/cell)

I hereby authorize Richard W. Pratt/Michael R. Melancon and its representatives and/or staff to share all medical and financial information with the following individual(s). The individuals listed below have authorization to talk to your staff on the phone and/or bring my child into the office. *Both parents will automatically have authorization unless court documents are presented specifically state one is not authorized.*

_____ I do NOT want to authorize anyone other than parent(s)/guardian(s).

_____ I give permission to fax immunization records or forms to my child's school: *(please give name of school & fax #).*

LIST CONTACTS THAT YOU WILL ALLOW TO COME WITH THE PATIENT:

NAME: _____ Relationship to patient: _____ PHONE #: _____

NAME: _____ Relationship to patient: _____ PHONE #: _____

NAME: _____ Relationship to patient: _____ PHONE #: _____

NAME: _____ Relationship to patient: _____ PHONE #: _____

I understand that authorization to anyone other than myself or the other parent/guardian is voluntary and I can revoke authorization at any time.

Authorized by: _____ Date: _____

JAN FEB MAR APR MAY JUNE JULY AUG SEPT OCT NOV DEC

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[1] SOLA MED DISCLOSURE 03/2017