



Patients 18 years or older

Authorization to Release Healthcare Information to Parent/Care Giver

Richard W. Pratt, MD

Michael R. Melancon, MD

200 Liberty Avenue

Lafayette, LA 70508

Office: (337) 989-8080

Fax: (337) 981-0913

Patient's Name _____ DOB _____

I request and authorize Sola Pediatrics to release healthcare information of the patient named above to parent/caregiver:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to patient: _____

This request and authorization applies to:

_____ All healthcare information, including lab results and diagnostic tests

_____ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24, includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, VDRL, chancroid, lymphogranuloma venereum, HIV/AIDS, and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, pregnancy testing, whether positive or negative, to the person listed above.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person listed above.

Yes No Do you have a Living Will and/or durable power of attorney for health care?

Financial Responsibility/Billing statements should be sent to:

Name: _____ Relationship: _____

Patient Signature _____ Date _____