Juliana Nahas MD.

Covington Pediatrics, LLC

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Patient Full Name | Paients Date of Birth

_____ _____

_____ _____

_____ _____

_____ _____

Please INITIAL ALL REQUESTED INFORMATION BELOW:

_____General Medical Info _____Laboratory Reports _____X-Ray/Radiology Reports

_____Mental Health (from_____ to _____) _____Alcohol/Drug(from_____ to _____)

_____HIV (from_____ to _____) _____STD's(from_____ to _____)

_____Other (Specify)_____

PLEASE PROVIDE US WITH THE FORMER PROVIDER'S INFORMATION BELOW:

Physicians Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

IF THE REQUEST IS TO RELEASE RECORDS TO ANOTHER PROVIDER PLEASE PROVIDE THE INFO BELOW:

Physicians Name: _____

Address: _____

City, State, Zip: _____

This authorization expires _____ or in 6 months, whichever is shorter. Authorization is subject to revocation at any time.
Once HIPPA information is disclosed to another entity the information may be subjected to future use and disclosure without protection offered by HIPPA.

Check One: I am the __Patient (must be 18 years or older) __Parent or __Legal Guardian with custody (please state relationship to the patient): _____

Signature: _____ Date: _____