DELTA PEDIATRIC CARE

202 East 3rd Street
Leland, MS 38756
Phone: (662) 580-5074
Fax: (662) 580-5253
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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 released: (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 Delta Pediatric Care, 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: _____