Pediatrics and Genetics

3510 Old Milton Parkway, Alpharetta, GA 30005

770.336.0132 Fax 770.346.0165

www.pediatricsgenetics.com

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name:_____ D.O.B: _____

Patient Name:_____ D.O.B: _____

I hereby authorize:

Pediatrics and Genetics, 3510 Old Milton Pkwy, Alpharetta, GA. 30005

To disclose the above name individual's health information as described below:
Date(s) of service Requested (if known) or Provider: _____

Description of information to be released: (check all that apply):
__ Immunization Record __Radiology /Imaging Reports __Most Recent History & Physical
__Radiology Films __Laboratory Reports __Consultations
__Progress Notes __Entire Medical Record __Other _____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used the following individuals or organizations:

Practice Name: _____
Phone: ( )____-_____ Address:_____
Fax: ( )____-_____ _____
Description of the purpose or the use and/or disclosure:
__Continuing Care __Second Opinion __Social Security
__Consultation __Insurance
__Legal Purposes __Personal Use

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by federal and state privacy regulations.

_____ _____
Signature of Patient's Representative Date

_____
Printed name of Patient's Representative

_____ OR _____
Relationship to Patient Legal Authority (attach supporting documentation)