Authorization for Release of Medical Records

Please release pertinent protected health information (medical records) for:

Child's name_______________________________ Date of birth____________________

Address____
____

Phone __________________________ Cell______________________

Also release records for the following children:
Sibling _______________________________ Date of birth _____________________
Sibling _______________________________ Date of birth _____________________
Sibling _______________________________ Date of birth _____________________

I authorize____
Address____
Phone# ___________________________**Fax#**________________________________
to release my protected health information as checked below to:

Dekalb Pediatric Center, PC
350 Winn Way
Decatur, Georgia 30030
Office - 404-508-1177 Fax- 404-508-9640

Please check information to be released:
__________Record from________ to ________
__________Entire record
__________Immunizations
__________Hospital Record
__________Lab Reports
__________X-ray Reports
__________Specific records:
____

Please check purpose of disclosure:(any that apply):
__________ Changing pediatricians
__________ For Continuity of Care
__________ Patient request
_________ Other:______________________

☐ Please fax immunization history ASAP to Dekalb Pediatric Center 404-508-9640
Other: ___________ ____________________________________

I understand that this authorization is valid for up to one year from today's date, or until _________________________________.
Expiration Date or Defined Event

I understand that I may revoke this authorization at any time by notifying the facility where I received medical care in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.

_________________________________ ____________________
Signature of Patient or Legal Guardian **Date**