Dekalb Pediatric Center

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I authorize release of my pertinent protected health information (medical records) for:

Child's name_________________________________ Date of birth____________________

Also release records for the following children:
Sibling ______________________________ Date of birth ____________________
Sibling ______________________________ Date of birth ____________________
Sibling ______________________________ Date of birth ____________________

Please check any that apply:
__________ Personal copy
__________ Moving out of area
__________ Changing pediatricians
__________ Specialist
__________ School
__________ Insurance
_________ Other ______________

Please check information to be disclosed:
__________Record from________ to ________
__________Entire record, ***excluding*** records generated prior to care at Dekalb Pediatric Center
(check here if you already have a copy of old records)
__________Entire record, ***including*** "old records" from previous doctors
__________ Immunizations Only
__________Specific Records Only:_____________

I authorize DPC to release my protected health information listed above to:
Name: ____
Address: ____
____

☐ Please fax immunization history ASAP to: ______________________________

I understand there is a **charge** to send records to reasonably cover the administrative costs of retrieval, copying, mailing, labor and supplies. Our fees are in accordance with Georgia state law.

- **The minimum charge for a record of 2-20 pages is $15.00. (Sibling records requested at the same time are $10.00 each.)**
- **An additional $0. 80 per page will be charged for each page over 20 pages.**
- **This may be paid by cash, check or charge when records are ready to be released. (Charge payments will also be accepted over the phone.)**
- **There is NO CHARGE for records to be sent to another physician we referred you to, a hospital where your child is receiving care, or records necessary to complete an application for a disability program.**

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 Dekalb Pediatric Center, PC 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** **Phone**

If not prepaid, or there is an additional amount due, you will be called prior to records being sent.
Please allow up to 5 business days to process your request.

FOR INTERNAL PURPOSES ONLY
# of pages __________________ Cost $______________________
Date paid: __________________ Date mailed: ________________