AUTHORIZATION TO RELEASE MEDICAL RECORDS

The Children's Doctors, P.C.
2366 Battlefield Parkway
Fort Oglethorpe, GA 30742
706-866-7384 Fax # 706-861-7003

Identification of Legal Guardian is required

Please print clearly

Legal Guardian Information

Name _____ Relationship to patient _____

Address _____ Home/Cell Phone # (_____) _____ - _____

City/State/Zip _____ Work Phone # (_____) _____ - _____

Social Security # _____ - _____ - _____ Date of Birth _____ / _____ / _____ License State ____ # _____

Patient Information

1. Name _____ Date of Birth _____ / _____ / _____
2. Name _____ Date of Birth _____ / _____ / _____
3. Name _____ Date of Birth _____ / _____ / _____
4. Name _____ Date of Birth _____ / _____ / _____

SECTION A

I authorize The Children's Doctors, P.C. to take the following action requested *(please initial by the appropriate action to complete the request)*

_____ Provide a copy to me

_____ Release my Medical Records to *(please complete information below)*

_____ Obtain my Medical Records from *(please complete information below)*

Name _____

Address _____

City/State/Zip _____

Telephone # (_____) _____ - _____ Fax # (_____) _____ - _____

SECTION B (Initial beside the information you request to be released)

I give special permission to release any information regarding: _____ Substance Abuse _____ HIV Information

The Children's Doctors, P.C. does not release psychotherapy notes of any form to any third parties, except those required by the HIPAA Privacy Rule. The patient's legal guardian must obtain psychotherapy notes from the originating psychotherapy provider.

SECTION C

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules.

Reason for request: _____

_____

Signed _____ Date _____ / _____ /_____