Children 1st Pediatrics
101 Beckett Lane, Suite 502
Fayetteville, GA 30214
Phone: (678) 817-1000
Fax: (678) 817-1001

_____
Patient Name

Date of Birth: _____

1. AUTHORIZE:

_____
Name of Sending Office

_____
Street Address

_____
City State ZIP

2. TO RELEASE TO:

_____
Name of receiving

_____
Street Address

_____
City State ZIP

INFORMATION to be RELEASED:

_____ **IMMUNIZATION RECORD** _____ **COPY OF MEDICAL RECORD**

_____ **SUMMARY OF MEDICAL RECORDS** _____ **OTHER** (Specify)_____

REASON FOR DISCLOSURE:_____

_____

_____ I understand that I, or the person authorized to act on my behalf, am entitled to receive a copy of this Authorization..

_____ The requester may be provided with a copy of this authorization.

_____ I understand that I may inskect my records and that a reasonable fee may be charged for the duplication of records. An estimate of charges will be provided upon request before duplication.

_____ I am aware of the consequences that may occur as a result of my signing this authorization request or my denial to do so. I understand that I may revoke this authorization in writing at any time ex;ept to the extent that action has been taken based on this authorization. I also understand that this authorization shall expire, without my express revocation, 90 days from the request date specified above.

_____ I am authorizing any physician, nurse, hospital or other provider having treated or attended, and having possession of any records and information with respect thereto, to provide such records to the requesting party identified above.

BY SIGNING BELOW YOU ARE AUTHORIZING THE REOUEST FOR RELEASE OF INFORMATION IDENTIFIED ABOVE

_____ _____ _____
Parent/Guardian Daytime Phone No. Date

_____ _____
Witness Date

NOTE TO DISCLOSING PERSON/PARTY: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulation (42C FR. Part2) prohibits you from making further disclosure of it without the specific written consent of the patient to who it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.