WEST ATLANTA PEDIATRICS

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Lithia Springs, GA. 30122
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Dallas, GA. 30157
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AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Release and/or disclose records and information regarding:

Patient Name: ________________________________ **Date of Birth:** ______________

I hereby request medical records be released from:

____
Physician / Practice

____
Street Address

____
City, State, Zip Code

______________ ______________
Phone Fax

I hereby request medical records be sent to:

____
Physician / Practice

____
Street Address

____
City, State, Zip Code

______________ ______________
Phone Fax

- ☐ Pertinent Medical Records
- ☐ Immunization Records
- ☐ Information about drug or alcohol abuse
- ☐ Other____
- ☐ Lab Reports
- ☐ HIV Status
- ☐ Psychiatric Records (ex: ADD Records)

**Pertinent Medical Records will include: Immunization Record, Most Recent Well Checkup, Growth Chart, Consultation reports, lab reports, & x-ray reports for the last 12 months, and Patient Summary which includes Medication list, visit dates, and diagnoses.*

Requested Date(s) From: __________________ **To:** __________________

Reason for leaving: ____

I hereby authorize the releasing facility to release information as indicated. The releasing facility is hereby released from all legal liability that might arise from the release of the information requested. I understand that my records are protected and cannot be disclosed without my written permission, with the exception of information released pertaining to treatment, payment, or healthcare operations as specified by HIPAA or as required by law. This request shall remain valid until revoked, or upon the expiration of sixty (60) days, whichever occurs first.

Parent/Guardian Signature: __________________ **Name printed** ______________________

Relationship to patient: ____________________

Date: ________________________ **Phone Number:** ____________________________

FOR OFFICE USE ONLY

☐ PARENT PICKED UP RECORDS ☐ FAXED RECORDS ☐ MAILED RECORDS