Duluth Children's Medicine, PC
3500 Duluth Park Ln, Suite 220
Duluth, GA 30096-3230
(678) 878-2808 (p) / (949) 250-6950 (efax)

Authorization for Release of Medical Records

I am requesting that the medical records for my child/children:

Patient's Name _____ Date of Birth _____

Patient's Name _____ Date of Birth _____

Patient's Name _____ Date of Birth _____

Be transferred TO or FROM (Circle one):

Name or Previous Doctor/Practice _____

Address _____

City, State Zip _____

Phone _____ Fax _____

TO or FROM (Circle One):

Duluth Children's Medicine, PC

3500 Duluth Park Lane, Suite 220

Duluth, GA 30096-3230

(678) 878-2808 (phone) / (949) 250-6950 (efax)

The release of information to which I consent is for the purpose of: _____

_____

I understand this authorization includes the release of all medical records including HIV records, mental health records, drug/alcohol abuse records, venereal disease and any other statutory protected diseases. This authorization will expire 90 days following the date signed unless otherwise noted. I understand that I may revoke this authorization and consent at any time except that the action has previously taken in reliance hereof. By signing this form, I am authorizing you to disclose protected health information about my child/children.

Signature of Patient or Legal Guardian _____

Relationship to Patient: _____

Date _____ Expiration date _____