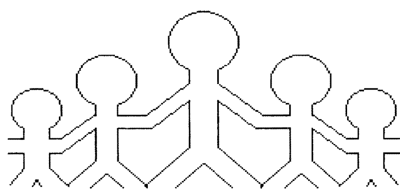

Lawrenceville Pediatrics, P.C.

Authorization for Release of Medical Records to Lawrenceville Pediatrics, PC

Indicate name of physician/group that you are requesting records from:

Name of Previous Pediatrician: ______________________________ Phone#__________________

Address:____ Fax #___________________

City/State/Zip:____

I am requesting that the medical information for my child/children to be transferred to:

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

____

{ }3815 Harrison Road
Loganville, Georgia 30052
Phone: 770-466-6112
Fax: 770-466-6201

Patient's Name:_______________________________________ Date of Birth:______________

Patient's Name:_______________________________________ Date of Birth:______________

Patient's Name:_______________________________________ Date of Birth:______________

Patient's Name:_______________________________________ Date of Birth:______________

I understand this authorization includes release of all medical records including HIV Records, Psychiatric Mental Illness, Drug/Alcohol Abuse Records, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire (90) days following the date signed. 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 authorization, I am authorizing you to disclose the following protected health information about my child/children.

____ ______________

Signature of Parent/Guardian Date

Expiration Date_________ MA Initials_________