



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:

{ } 980 Lawrenceville Highway
Lawrenceville, Georgia 30046
Phone: 770-962-8025
Fax: 770-822-1573

{ } 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 _____