

## Authorization for Release of Medical Records

Please release pertinent protected health information (medical records) for:

Child's name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_

Also release records for the following children:

Sibling \_\_\_\_\_ Date of birth \_\_\_\_\_

Sibling \_\_\_\_\_ Date of birth \_\_\_\_\_

Sibling \_\_\_\_\_ Date of birth \_\_\_\_\_

I authorize \_\_\_\_\_ Phone# \_\_\_\_\_

Fax# \_\_\_\_\_ to release my protected health information as checked below to:

**Dekalb Pediatric Center, PC**  
**350 Winn Way**  
**Decatur, Georgia 30030**  
**Office - 404-508-1177 Fax- 404-508-9640**

Please check information to be released:

\_\_\_\_\_ Record from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Entire record

\_\_\_\_\_ Immunizations

\_\_\_\_\_ Hospital Record

\_\_\_\_\_ Lab Reports

\_\_\_\_\_ X-ray Reports

\_\_\_\_\_ Specific records:

\_\_\_\_\_

Please check purpose of disclosure:(any that apply):

\_\_\_\_\_ Changing pediatricians

\_\_\_\_\_ For Continuity of Care

\_\_\_\_\_ Patient request

\_\_\_\_\_ Other: \_\_\_\_\_

Please fax immunization history ASAP to Dekalb Pediatric Center 404-508-9640

Other: \_\_\_\_\_

**I understand that this authorization is valid for up to one year from today's date, or until**

\_\_\_\_\_.  
**Expiration Date or Defined Event**

**I understand that I may revoke this authorization at any time by notifying the facility where I received medical care in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.**

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

\_\_\_\_\_  
**Date**