

The following form may be printed. After it is completed and signed the parent or guardian, you may fax it to us at 770-475-1621 or you may bring it to our office. As a courtesy we will forward the continuation of care records free of charge (growth charts and problem list): if requested more than once there will be a fee. Standard fees apply for a copy of the complete record.

North Fulton Pediatrics, LLC Medical Record Release Form

Authorization for use and disclosure of protected health information

I, the undersigned parent/guardian, hereby authorize North Fulton Pediatrics, P.C. to release copies of medical records for my child(ren) named below for:

- | | |
|---|--|
| <input type="checkbox"/> All medical records | <input type="checkbox"/> Immunization records only |
| <input type="checkbox"/> X-rays only | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Continuation of care | <input type="checkbox"/> 3231 Immunization school form |
| | <input type="checkbox"/> 3300 Vision and hearing school form |

For the following date (s) of service, type of services, etc.:

Patient's name and date of birth:

Patient's name and date of birth

Patient's name and date of birth

Patient's name and date of birth

Please send copies to:

(Parent or Guardian address)

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

Insurance change Which insurance plan?

Specialist care Moving in state Moving out of state Other

If other please explain:

I understand this authorization includes release of all medical records. This authorization and consent will expire ninety (90) days following the date signed unless I choose to revoke in writing prior to the expiration date. We only release our records. Please note because of the HIPAA guidelines, we are not allowed to release any psychological testing records or records from specialists. You must request those from the specialists that provided the service.

Parent/Guardian Signature

Date

Print name of Parent/Guardian