# TOTAL CARE PEDIATRICS

Thornton , Suite Lithia Spring, GA. 30122
Phone: 470.502.0202 Fax: 470.582.9386

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Release and/or Disclose records and information regarding:

Patient Name:_____ Date of Birth:_____

I hereby request Medical Records be released from:

_____
Physician/Practice

_____
Street Address 1

_____
Street Address 2

_____
City, State, Zip Code

_____ _____
Phone Fax

I hereby request Medical Records be released to:

_____
Physician/Practice

_____
Street Address 1

_____
Street Address 2

_____
City State, Zip Code

_____ _____
Phone Fax

___ Entire Medical Record

___ Immunization Record

___ Drug or Alcohol information

___ Lab reports

___ Pertinent Medical Records

___ STI labs (not including HIV)

___ HIV result

___ Radiological (CT, MRI, X-Ray)

___ Other (describe) _____

Requested Date(s) From: _____ To: _____

Request Reason: _____

I hereby authorize the releasing facility to release information as indicated, above. The releasing facility is hereby released from all legal liability that might arise from the release of the information requested. I understand that my records are protected and can not be disclosed without my written permission, with the exception of information released pertaining to treatment, payment, healthcare operations, as specified by HIPAA, or as required by law. This release shall remain valid until revoked or upon expiration of sixty (60) calendar days, whichever occurs first.

Parent/Guardian Signature _____ Printed Name_____

Relationship to patient_____

Date: _____ Phone number: _____

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FOR OFFICE USE ONLY

____ PARENT PICKED UP RECORDS ____ RECORDS FAXES _____ RECORDS MAILED