PEDIATRICS AT WHITLOCK
MEDICAL RECORDS RELEASE

611 Campbell Hill St NW Suite 103
Marietta, GA 30060
(770) 499-8909 Fax (770) 499-8911

Patient Name: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____
Email address: _____
I authorize representatives from the following facility to disclose the health information

From:	To:
Name/Place: _____ Address: _____ _____ Phone: _____ Fax: _____	Name/Place: _____ Address: _____ _____ Phone: _____ Fax: _____

Information To Be Disclosed:
❑ Complete medical record (Please specify dates of service): _____
OR
Partial Medical Record (Please specify records below):
❑ Well Visits ❑ Problem visits
❑ Referral Records ❑ Lab results
❑ X-rays ❑ Vaccine Records
❑ Other:_____
Purpose of Disclosure:
❑ Moving ❑ Legal Purposes ❑ Insurance Purposes
❑ Other: _____

I understand that:

- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here: _____.
- I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the clinic or department where my Authorization was made or given.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.
- **Outgoing medical records are subject to $25 fee prior to release due at time of release.**

Signature of Patient/Parent: _____ **Date**: _____
Printed Name: _____