Woodstock Pediatric Medicine, P.C.

2000 Professional Way, Bldg. 200 Woodstock, GA 30188 Phone: 770-517-0250 Fax: 770-517-0260

Release of Medical Information

I hereby request and authorize Woodstock Pediatric Medicine to use and disclose protected health information (PHI) for the following child(ren) listed below:

Patient's Full Name:_____ Patient's Date of Birth:_____

Patient's Full Name:_____ Patient's Date of Birth:_____

Home Phone #:_____ Cell/Other Phone#:_____

Current Address:_____ City/State/Zip:_____

This Authorization applies to the following date(s) of service:_____

Complete Medical Records ($25.00 per child)
Patient Summary of all visits
Chart Notes
Consultation Notes
Radiology/EKG/Lab Reports
Other:_____

Medical Record Fee must be paid before the records are printed. These charges only apply if Woodstock Pediatric Medicine is releasing the records. Fee is not required for records when released directly to another physician.
Reason for Request to Release Complete Medical Records:
Review by Specialist, Surgeon, or Therapist
Moving from Area
Other (Please specify):_____

Please release the requested records to:

From:_____ To:_____

Woodstock Pediatric Medicine

From:_____ To:_____
Practice Name:_____
Address:_____
Phone:_____ Fax:_____

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that entity identified above has taken action in reliance on this Authorization. I further understand that this Authorization is specific to the information checked above, for the date(s) of service indicated, and for the purpose written above. Woodstock Pediatric Medicine shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams).

_____ _____ _____
Signature of Patient/Legal Guardian Printed Name of Signing Party Today's Date

Relationship to patient _____. If relationship is other than parent, documentation of legal authorization or Guardianship may be requested