

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Phone Number:** _____

Authorization is hereby granted to release or obtain a complete copy of the above named patient's entire medical record. Including but not limited to office notes, hospitalization reports, immunization records, growth charts, lab & x-ray reports, etc.

I authorize Bulloch Pediatrics Group to obtain records from:

or

I authorize Bulloch Pediatrics Group to release records to:

Name of entity or physician

Name of entity or physician

Address

Address

City State Zip Code

City State Zip Code

Phone Number: _____

Phone Number: _____

Specific date(s) of treatment requested if not all: _____

Specific information requested if not all: _____

I authorize the use and/or release of my child's protected health information as described above. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or pay claims. I have the right to revoke this Authorization by providing written notice to Bulloch Pediatrics Group Medical Records Department. Revocation of this Authorization will not affect any action taken before the receipt of the written revocation.

Signature of Patient or Parent/Guardian

Signature of Witness

Printed Name

Relationship to Patient

Date