North Fulton Pediatrics

NORTH FULTON PEDIATRICS, PC

1285 Hembree Road, Suite 100, Roswell, GA 30076 / Fax: (770) 475-1621

MEDICAL RECORDS/AUTHORIZATION RELEASE FORM

Please print and fill out this Medical Records Authorization Release Form. After this form is completed and signed, the patient/parent/ guardian may fax this form to: (770)-475-1621. Or, you may bring it to our office.

**** Required fields.*** As a courtesy, we will forward the continuation of care records free of charge. However, if additional medical records are required, there would be a fee for this service.

Note if patent is 18 years of age or older, they are required to sign for their own medical records.

*I, _____ the undersigned patient/parent/guardian, hereby authorize
(Please print person requesting records)
*North Fulton Pediatrics, PC to release Medical Records for myself/child(ren) named below for:

_____All medical records (fee required)
_____Copy of immunization only
_____X-ray/Lab results only
_____3231 Ga. Immunization Form (fee required)
_____Continuation of care (summary of records only)
_____3300 Ga. Form (fee required)

***** See below statement regarding HIV / Psychiatric / Drug / Alcohol /VD / records*****

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* Release Dates of Services: FROM: ____/___/____ TO: ____/____/_____ (Fee may be required)

*_____/____/_____
#1 Patient's name and date of birth

_____/____/_____
#2 Patient's name and date of birth

_____/_____/_____
#3 Patient's name and date of birth

_____/_____/_____
#4Patient's name and date of birth

Please send copies of medical records to:

*Name of Doctor/Patient/Parent/Guardian: _____
*Address of above: _____City_____Sate_____Zip_____
Phone number: (___)_____ * Fax number: (___)_____

* *The medical records which I have consented to be released are for the reason(s) below:*

___Insurance change/Name of Ins.:_____
____Dissatisfaction w/ Provider
___Dissatisfaction w/Staff (which staff member)_____
____Location inconvenient
___ Referred to Specialist _____
____Moving in/out State _____
Other: _____

I understand, this authorization does not include release of medical records that include HIV records, Psychiatric Mental Illness, Drug/Alcohol abuse records, Venereal Disease, any other statutory protected diseases, any records from previous physicians or specialist, per HIPAA guidelines. If you would like these records to be released please initial here: _____.

This authorization and consent will expire ninety (90) days from the date signed, unless I choose to revoke in writing prior to the expiration date.

_____ _____

***Patient/Parent/Guardian Signature** ***Date (expires in 90 days)**