

Authorization for Release of Medical Information

Patient Name: _____

DOB: _____

I, _____, hereby authorize the release of medical information **TO:**

Briarvista Pediatrics
2244 Henderson Mill Road, Suite 108
Atlanta, GA 30345
770.239.2500 (office) 404.745.8202 (fax)

FROM:

Doctor/Clinic/Hospital: _____

Address: _____

Telephone: _____ Fax : _____

Please release the following:

All health information (including growth charts and vaccination records)

History/Physical Exam

Diagnostic Test Reports

Progress Notes

Radiology/Images

Discharge Summary

Lab Results

Consultation Reports

Pathology Reports

Other (specify): _____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases, and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

Yes, I consent to the release of this information.

No, I do not consent to the release of this information.

Purpose of disclosure:

Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____



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Phone 770.239.2500
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Website www.briarvistapediatrics.com