Creekview Pediatrics
caring for your child From birth to 21 yrs

3925 Johns Creek Court
Suite D
Suwanee, GA 30024

Phone (770)622-7742
Fax (770)622-7743

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ DOB: _____

*****PLEASE FAX RECORDS TO 770-622-7743*****

I authorize Creekview pediatrics to ***obtain*** information from:	**OR**	I authorize Creekview pediatrics to ***release*** information from:
_____ Name of provider or facility		_____ Name of provider or facility
_____ Address		_____ Address
_____ City, State, Zip code		_____ City, State, Zip code
_____ Phone # Fax#		_____ Phone # Fax#

I am aware if the medical record has information regarding substance abuse mental health, communicable diseases, tuberculosis, or genetics. This information may be released unless indicated by checking here _____

Records Requested- please check one

_____ **Medical Record:** All growth chart's, recent labs, last well check/ office visit, all immunizations to date, and birth records. _____ **Immunizations only** _____ **Other** (please specify) _____

Purpose of disclosure: ___ Move ___ Transfer of care ___ Insurance change __Personal __Legal

I authorize the release of medical information to another provider/ facility as deemed necessary for my treatment. I further authorize Creekview Pediatrics LLC. To obtain medical information form another provider/ facility as deemed necessary in the course of my treatment. This authorization will expire in sixty (60) days from the date of signature and this authorization may be subject to re-disclosure and longer protection by HIPPA. My health care and payment for my health care will not be affected by refusing to sign this form. I understand that I may see and copy the information described on this form as requested. I may cancel this authorization at any time by submitting a written request to Creekview Pediatrics. I understand that the revocation will not apply to information that has already been released to response to this authorization. I understand there is a fee for copying medical records.

All Records require at least 5 business days to process, to protect your privacy, the patient/ legal guardian will be required to pick records up in person and provide valid photo ID. Please provide Phone number to be collected when records are ready for pickup: _____

_____ _____ _____

Signature of Patient or Authorized Representative Name (please print) Date

(must be 18 years or older)