AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name_____ Date of Birth_____/_____/_____
Last First Middle Initial

I authorize the following organization to release all health care information as stated below to the organization listed:

INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:
_____ Organization/Person Name _____ Street Address _____ City, State, Zip _____ Telephone/Fax Number	Tri-County Pediatrics 808 Commerce Blvd Suite A Riverdale, GA 30296

THIS REQUEST APPLIES TO (Charges for copies of records may be associated with your request)

- o Transferring Physicians
- o Continued Medical Care
- o Legal Action/Review
- o Insurance Requirement
- o Other_____

Daytime Telephone (_____) _____

Address: _____

Signature:_____Date:_____
Parent/Guardian

I understand this authorization will expire in 90 days after the date below and covers only treatment prior to that date. I understand that I may revoke in writing this authorization at any time. I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy law. I acknowledge that a revocation will not affect actions already taken in reliance on the authorization form. I also consent to the release of medical information which may contain treatment for physical and/or emotional illness, communicable disease, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS related information. I understand this authorization will expire in 90 days after the date below and it covers only treatment prior to that date. I also understand that I may revoke in writing this authorization at any time.

808 Commerce Blvd, Suite A ~ Riverdale, GA 30296 ~ (770)996-9191 FAX (770)996-5298
1240 Hwy 54 West, Suite 100 ~ Fayetteville, GA 30214 ~ (770)461-5040 FAX (770)461-5041
193 North Park Trail, Suite 100~ Stockbridge, GA 30281 ~ (770)389-0116 FAX (770)389-4058

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