Tri-County Pediatrics
Healthy Child Happy Family

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:
1240 Hwy 54 W Suite 100 Fayetteville, GA 30214 Office(770) 461-5040 Fax (770) 461-5041	_____ Organization/Person Name _____ Street Address _____ City, State, Zip _____ Telephone/Fax Number

- 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.