White's Pediatrics of Dalton, Chatsworth & Calhoun

Authorization for the Release of Patient Information

Patient Name: ________________________ **DOB:** ___/___/____ **SSN:** ______-_____-______

I authorize ______________________________ (Phone: ____________________) to release
(doctor who has records)

the following medical record information to ______________________:
(person/doctor to receive records)

- ☐ Copy of patient's entire medical record
- ☐ Medical records for the following date(s) of service: ______________________
- ☐ Vaccination records
- ☐ Lab results only for the following date(s) of service: ______________________
- ☐ X-ray film(s) for the following date(s) of service: ______________________

The reason for releasing these records is:

- ☐ Legal proceedings or request by attorney
- ☐ Moving out of state
- ☐ Change of insurance
- ☐ Switching doctor (Reason for switching: ______________________)
- ☐ Other: ______________________

I want the following person/doctor to receive the records:

Name: ____

Address: ____

Phone Number: ______________________ Fax: ______________________

I understand that:

- I do not have to give my permission to share these records.
- If I want to take away the permission to share these records, I must sign a paper saying that I revoke my permission.
- If the requestor or receiver is not a health plan or health care provider, these records may no longer be protected by federal privacy regulations and may be re-disclosed.
- I have the right to see and obtain a copy of my records.
- **Records released may include information about genetic conditions, psychiatric conditions, HIV/AIDS, STDs, and substance abuse.**
- This form is only good for 3 months from the date I sign it.

Signature of Parent/Guardian: ____________________________ **Date**: ______________

Printed Name of Parent/Guardian: ____________________________

Relationship to Patient: ____________________________

This document must be made part of the patient's medical record.