

Medical Record Authorization

Date: _____

Physician's Name: _____

Physician's Phone Number: _____

Address: _____

I authorized my previous medical provider listed above to release my Medical Record Information to *Dekalb Pediatric Associates, P.C.*, Suite 180, 1370 Montreal Rd, Tucker, GA 30084.

Patient's Name: _____ Birth Date: _____ Sex: F M

Patient's Name: _____ Birth Date: _____ Sex: F M

Patient's Name: _____ Birth Date: _____ Sex: F M

Patient's Address: _____

Mother's Name: _____ Father's Name: _____

Information to be released:	Purpose of Disclosure:
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Date of Services please list dates _____

History and physical exams

Specialties Notes

X-Ray Reports

Lab Reports

Immunization Record

Changing Physician

Second Opinion

Legal

Insurance

School

Other

I understand that I may revoke this authorization at any time by notifying *Dekalb Pediatric Associates, P.C.* in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.

(Signed by Patient/Parent/Legal Guardian)

(Date Signed)

(Relationship to Patient)

(Expiration Date or Defined Event)

Name of Person or Facility: _____	
Faxed Number: _____	Date Faxed: _____

