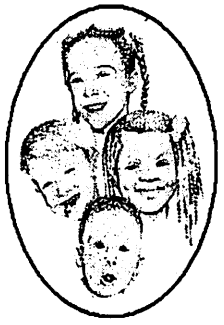

ATHENS PEDIATRICS, PLLC

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Authorization to Release Medical Records

☐ Send records to Athens Pediatrics (please do not fax more than 20 pages).

☐ Transfer records from Athens Pediatrics

Physician/ Facility/ Hospital: _____ Phone: _____
Address: _____ Fax: _____
City: _____ State: _____ Zip: _____

Patient's Name	Birthday
_____	_____
_____	_____
_____	_____

Reason for records request: _____

PLEASE SEND ALL RECORDS EXPECT AS LISTED BELOW.

PLEASE INIDICATE BY INITALING BELOW NEXT TO THE INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE YOUR RECORDS WILL BE RELEASED AS SPECIFIED.
I authorized _____ to release the medical information specified to the above named with the EXCEPTION of:
____ Substance abuse, if any ____ AIDS/HIV, if any
____Psychological or psychiatric conditions, if any Other: _____

You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of Athens Pediatrics, PLLC. Unless an earlier date is specified it will automatically expire 12 months from the date signed.

This Authorization was signed by: _____
(Print name- Parent, Guardian, or Patient)

Relationship to Patient (if other than patient): _____

SIGNATURE: _____ DATE: _____

I understand that by forwarding my records to another primary care physician, this will end my relationship with Athens Pediatrics as a patient and that I may not be able to return to this practice.