MITCHELL COUNTY
PEDIATRICS AND HEALTH CENTER

94 East Oakland Ave
Suite A
Camilla, GA 31730
Phone: 229.336.9769
Fax: 229.336.3867
Email: info@mitchellphc.com

Request For Release of Records:

Physician's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

The following individual has asked to request that his or her medical records be released and forwarded to our office.

Patient Name: _____ SSN: _____

DOB:_____

In order to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records. Please be sure to include x-rays reports and immunizations. Thank you for expediting this request. Please send records to the office address shown above.

I hear by authorize the release of all necessary medical records to Mitchell County Pediatrics and Health Center. I wish for them to be forwarded as soon as possible. I understand that my records have privileged and confidential status. I am waiving that the purpose stated and authorization the release of information may also be recorded in the family medical care, this information concerning AIDS/HIV testing or pertinent family medical care, this information may also be recorded. OB care information may also be recorded in the infant's chart. No threat, promise, or offer of any kind has been made to me by any employee or representative of the medical facility in connection with this release, and I have executed it on my own free will. I understand that I may revoke this consent at any time unless stipulated above for a special condition purpose. Revocation has no effect on action previously taken in reliance on this release.

Patient Signature: _____ Date: _____
(Or parent if patient is a minor)

Patient Address:_____
_____

Signature of Witness: _____ Date: _____