Authorization for Release of Health Information

Patient Name ____________________________________ Date of Birth _________________

The person named above is or has been a patient of

Name of Person,
Provider or Facility ____

Address ____

Phone ____

Fax ____

Please MAIL a copy of the requested medical records to

Heart and Soul Pediatrics
1880 West Oak Parkway, Suite 101
Marietta, GA 30062
Phone: 770-345-0055
Fax: 770-345-0020

Scope

- ☐ Complete medical record regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease
- ☐ All information regarding care received by patient between the starting date of ___________ and the ending date of ___________

I am aware that some of the information in the requested medical records may be of a sensitive nature. By signing this release, I am granting permission for information pertaining to the above-mentioned areas to be released. I waive any privilege or confidentiality existing under Federal or State law regarding such information.

Authorization

____
Printed Name of Patient or Authorized Representative

____ ____________________________
Signature of Patient or Authorized Representative Date

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Other (specify): ____