Primary Care Pediatrics, P.C.
763 Peachtree Parkway, Suite 2
Cumming,GA 30041
P:678-208-2050
F:678-208-2051

AUTHORIZATION TO DICLOSE PROTECTED MEDICAL RECORDS / INFORMATION

Patient Name:_____DOB: _____/_____/_____

Patient Address:_____

Phone # : _____-_____-_____ Email:_____

Reason for Release of Records:_____

Type of medical records/ information needed to be released:

___ ENTIRE Medical Records
___ Last 3 Years of Medical Records
___ Urgent Care Visits
___ X-Ray Results
___ Growth Charts
___ Immunization Records
___ Specialties (specify): _____
___ Labs (bloodwork, strep test, etc.)

Other:_____

I authorize *Primary Care Pediatrics Dr Margaret Boudreaux, M.D., FAAP* to obtain my medical records from:

Office Name:_____
Phone # :_____-_____-_____
Fax # : _____-_____-_____
Email: _____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorizations in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been release as specified by this authorization or to my insurance company. I understand that treatment, payment, enrollment, or eligibility benefits will not be conditioned on obtaining your authorization for release of records. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I accept FULL financial responsibility for copying fees, shipping fees, and applicable sales tax fees.

Patient Name (print):_____ Date:_____/_____/_____

Patient's Parent/Guardian Signature: _____