

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

**AUTHORIZATION TO DISCLOSE 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 release my medical records to:**

**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:** \_\_\_\_\_