



Medical Records Release Authorization

Patient's Name		DOB	
Patient's Name		DOB	
Patient's Name		DOB	
Patient's Name		DOB	
Patient's Current Address:			
Patient's Previous Address:			
Patient's Current Phone #:			
Previous Provider:			
Address:	City:	State:	Zip Code:
Office Phone:	Office Fax:		

The Personal Health Information Is To Be Disclosed To:

Kennesaw Pediatrics, P.C.
3745 Cherokee Street NW, Suite 401
Kennesaw, Georgia 30144
O: 770-429-1005
F: 770-429-8005

The Description of Information to Be Disclosed

<input type="checkbox"/> Immunization Records, Growth Charts, Problem List (Complete)
<input type="checkbox"/> All Records
<input type="checkbox"/> Other, (specify):
Reason for Requested disclosure: To Transfer or facilitate the medical care of the individual listed about

Please Read and Sign

I understand the following:

1. I authorize the release of Personal Health Information (PHI) to be disclosed to Kennesaw Pediatrics, P.C.
2. I may revoke the authorization at any time by providing written notice to the practice.
3. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization, or if the authorization was obtained as a condition of obtaining insurance coverage.
4. The practice will not condition treatment or payment based on my signing this authorization.
5. I am signing this authorization freely; no one has pressured or coerced me to sign this authorization.
6. The information disclosed in this authorization may be subject to re-disclosure by the practice and longer protected by federal law.
7. I know that I had an opportunity to review this authorization and understand the intent and the use.
8. I understand that I am entitled to a copy of this authorization, at the time of its execution. If so, I will make my request known.

PARENT/LEGAL GUARDIAN SIGNATURE

RELATIONSHIP TO PATIENT

DATE