Dr.Miniyar's Pediatrics, P.C.

Ph: 706-232-1300 Fax: 706-232-1039

Consent For Release Of Medical Information

Patient's Name_____ Date of Birth_____

Address: _____ Ph_____

I authorize Dr. Miniyar's Pediatrics, P.C. to release / obtain medical records to / from the following entity

Full name of the person/entity:_____

Address of the entity:_____

Phone number:_____ Fax Number:_____

Reason why the medical records are needed:

_____ At the request of the individual signing this authorization Other (Specify)_____

Medical records to be released for the following dates:

_____ All Dates From dates _____ to _____

Specific details about records to be copied & released: (Circle one)

Entire Medical Record / Other (Specify) _____

Unless I request in writing otherwise, this authorization will expire on_____ . If I do not specify an expiration date or event, this authorization will expire one hundred and eighty (180) days from the date which it was signed.

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.

I understand that any information disclosed pursuant to this authorization may be subject to re disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization in writing at any time by sending the revocation to the health care provider indicated above, except to the extent that action has already been taken in reliance on this authorization. A

I understand that a health care provider may decline to treat me if I refuse to sign this authorization only when the treatment is for the sole purpose of creating health information for disclosure to a third party. I further understand that the records/information to be released may contain or consist of information related to the following: contagious diseases (HIV/AIDS, tuberculosis, hepatitis, etc.); psychiatric treatment or psychotherapy notes; and drug/alcohol abuse (42 CFR Part 2) . I hereby waive any privilege concerning such information for the purposes of releasing it to the party or parties authorized above.

Parent/Guardian Full Name:_____

Parent/Guardian Signature:_____ Date_____

For Internal Use Only

Staff's FULL Name who received this form _____ Date Received_____

Date it faxed to outside agency _____ Staff who faxed it_____

Date record mailed to outside agency (If Applicable): _____Staff who maile it_____

Notes: