South Georgia Pediatric and Allergy Center, P.C.

3331 North Valdosta Road Valdosta, Georgia 31602
(229)-247-2211 – (229)249-9490 Fax

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

______________________________ ______________________________
(PRINT PATIENTS Full name) (PATIENTS Date of Birth)

______________________________ ______________________________
(Print name of Parent/legal guardian if under 18) (Day phone number w/area code)

Name and Address of Office/Hospital from whom your seeking Medical Records:

____
____
____

Telephone: ______________________________
Fax: ______________________________

Check One: ___ I am the Patient (must be 18 or older)
___ Parent
___ Legal Guardian w/custody

Mail or Fax records to:
South Georgia Pediatric and Allergy Center
3440 North Valdosta Road
Valdosta GA 31602
Fax to 229-249-9490

- I place no limitations on history or illness (Including HIV and or AIDS, genetic, drug dependency or psychiatric information) or diagnostic and therapeutic information, including treatment for alcohol or drug abuse, or psychiatric disorders.
- I authorize the inspection of the above information by the above named agency.
- I understand that unless otherwise limited by state or federal regulations, I may withdraw this consent at any time by submitting my withdrawal request in writing.
- I hereby acknowledge that I have read or have had read to me, the above statements, and I fully understand the above statements and do expressly and voluntarily authorize the disclosure of medical information to the agency listed above.

Purpose of Release of Protected Health Information is:
___ Transferring Physicians
___ Continued Medical Care
___ Legal Action/Review
___ Insurance Requirement
___ Other ______________________________

This authorization expires in 6 months (12 months for school request) unless otherwise disclosed : ____________________

Authorizing Party :______________________________Date:______________
Witness Signature:______________________________Date: ______________