South Georgia Pediatric & Allergy Center, P.C.

3440 N. Valdosta Road
Valdosta, Georgia 31602
Phone: 229.247.2211 Fax: 229.249.9490

Alan J. Alvarado, M.D.
Board Certified Pediatrics
Board Certified Allergy and Immunology

Robert J. Criscuola, M.D.
Board Certified Pediatrics

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

_____ _____
PRINT PATIENT'S NAME PATIENT'S DATE OF BIRTH

_____ _____
PRINT NAME OF PARENT/LEGAL GUARDIAN PHONE NUMBER

Previous Provider Practice & Name: _____
Address:_____ City, State: _____Zip:_____
Phone:_____ Fax: _____

Check One:

I am the _____Patient (if 18 or older)
_____Parent
_____Legal Guardian with custody

Records to be Released:

_____All records including immunization records
_____:Other: _____

Purpose of Release of Protected Health Information is:

_____Transferring Physicians
_____Continued Medical Care
_____Legal Action/Review
_____Other:_____

This Authorization expires in 6 months (12 months for school requests) unless otherwise disclosed:_____

Mail Paper Copy/Disc or Fax Records to:
South Georgia Pediatric and Allergy Center, P.C.
3440 North Valdosta Road
Valdosta, Georgia 31602
Fax: 229.249.9490

- I place no limitations on history of illness (including HIV and/or AIDS, genetic, drug dependency psychiatric information) or diagnostic and therapeutic information (including treatment for alcohol/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 and do expressly and voluntarily authorize the disclosure of medial information to the agency listed above.

Guarantor: _____ **Date:**_____
SGPAC Witness: _____ **Date:**_____