MOUNTAIN VIEW PEDIATRICS

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient _____, Date of Birth___/_____/_____

Address_____

City_____ State_____ Zip_____

Phone_____ E-mail_____

Mothers Name_____ Fathers Name _____

HERBY REQUEST AND AUTHORIZE: MOUNTAIN VIEW PEDIATRICS

2049 Beverly Road Gainesville, GA 30501

Telephone # 770-287-1788 Fax # 770-287-7020

To: Obtain From OR Release to: (please circle one)

_____

Telephone #:_____ Fax :_____

IF OVER 10 PAGES, PLEASE MAIL------DO NOT FAX

The following types of information from my records:

_____ 1. ANY and ALL or

_____ 2._____

I understand this authorization includes release of all medical records including HIV records, psychiatric drug/alcohol abuse records, venereal disease, and any other statutory protected disease. All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will expire in 90 days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has been previously taken in reliance hereof. I also understand that once I have medical records transferred from this office, I may no longer have the option to return to this practice for medical treatment. The decision will be to the discretion of the practice.

_____ _____/_____/_____

Signature of Individual or Legal Representative Date of Signature

_____ _____

Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Individual