MOUNTAIN VIEW PEDIATRICS

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, Date of Birth _____/_____/_____
Patient Name

HEREBY REQUEST AND AUTHORIZE:

MOUNTAIN VIEW PEDIATRICS
2049 Beverly Road, Gainesville, Georgia 30501
Telephone: 770-287-1788 | Fax: 770-287-7020

To: Obtain From OR Release To: (Please Circle)

_____

_____

_____

Telephone: _____ Fax: _____

The following types of information from my records:

_____ 1. ANY and ALL or

_____ 2. _____

IF TRANSFERRING OUT OF OUR OFFICE, PLEASE STATE REASON FOR LEAVING:

___Moving ___Unsatisfied with Practice ___Doctor Change ___Other:

_____

I understand this authorization include 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.

_____ _____ / _____ / 2014
Signature of Individual or Individual's Legal Representative **Date of Signature**

_____ _____
Print Name of Legal Representative (If Applicable) **Relationship of Legal Representative to Individual**