AGC PEDIATRICS, LLC

7311 Fairmount Hwy
Calhoun, GA 30701
(706)625-5900

204 Professional Court
Calhoun, GA 30701
(706)625-5900
Fax (706) 625-5906 or 706-625-6519

100 Market Place Blvd., Suite 201
Cartersville, GA 30121
(706-625-5900

Authorization for Disclosure of Health Information

Patient Name ______________________________ DOB_____/______/______ Phone # __________________

PLEASE **OBTAIN** INFORMATION **FROM**:

____
Name of Provider/Clinic/Organization

____
Street Address

____
City, State, Zip Code

__________________ __________________
Phone Fax

PLEASE **SEND** INFORMATION **TO**:

____
Name of Provider/Clinic/Organization

____
Street Address

____
City, State, Zip Code

__________________ __________________
Phone Fax

I AUTHORIZE the following information to be disclosed: (Please initial all that apply)

__________ Entire Record
__________ Immunization Record
__________ Lab Test
__________ TB test
__________ HIV Record
__________ STD Record
__________ Behavior/Psychiatric
__________ Billing Record
__________ Other ______________
__________ Alcohol/Substance Abuse

REASON for disclosure of health information: (Please initial)

__________ At my request
__________ School
__________ Legal
__________ Continuing Care
__________ Insurance
__________ Other______________________________
____
____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization. To withdraw, please give written notice.
- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected by AGC PEDIATRICS, LLC
- I understand that signing this authorization does not cancel any rights I have under the other state or federal laws.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extend indicated and authorized herein.

____
Patient or Legal Guardian

____
Date

____
Relationship/Authority

____
Witness

_________ Fee Explained _________ ID Needed _________ Pick-up Records _________ Mail Records _________ FAX Records