AGC Pediatrics, LLC

HIPPA AUTHORIZATION to Release MEDICAL RECORDS
(FROM AGC PEDIATRICS)

Facility Use Only
MRN _____

PATIENT Name _____ Date of Birth _____
Last First MI

Address _____ Phone _____
Street City State Zip

Release **TO** the following Person(s) or Organizations:

Name: _____

Address: _____
Street City State Zip

Phone: _____ *Fax:* _____

Person *or Place that is requesting records:*

☐ Patient/Parent/Guardian ☐ Doctor/ Hospital ☐ Lawyer ☐ Insurance Company ☐ Other _____

Reason records are needed:

☐ Patient Care ☐ Disability ☐ Insurance ☐ School ☐ Legal ☐ Other _____

Release the records checked below, ☐ verbally ☐ on paper or ☐ electronically (if available)

☐ Visit/Discharge Summary ☐ Radiology Report (x-rays, MRI, CT scan) ☐ Image on disc ☐ Pathology report
☐ Lab results (blood work) ☐ Vaccination (shot) record ☐ Billing records ☐ HIV or ☐ STD
☐ Behavioral or Mental Health records ☐ Other _____
☐ Entire chart* ・includes all physician notes, consults, OT/PT speech ancillary records, ER records, Referral records, after visit summaries, immunization records, radiology reports, lab reports)

Treatment dates *(if not specified, the **LAST 6 MONTHS** will be sent):* _____

This authorization expires one year from the date of signature, OR on this date/event: _____

I understand that treatment does not depend on me signing this Authorization.

I understand that my/my child's/my ward's medical record might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse.

I understand that if I release records to someone other than a doctor, insurance company, hospital or other health related organization, these records may no longer be protected by the Federal privacy regulations, and this person or organization might release the records to someone else.

I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Privacy office, in writing at AGC Pediatrics, 204 Professional Court SE, Calhoun, GA 30701.

_____ _____ _____
Signature of Patient or Parent/Legal Guardian Printed Name Date

My relationship to the patient is:

☐ Parent ☐ Legal Guardian * ☐ Self ☐ Other _____
*Attach Court order to show your authority to sign

_____ _____ _____
Signature of Witness Printed Name Date

AGC Pediatrics, LLC

HIPPA AUTHORIZATION to Release MEDICAL RECORDS

(Send Records to AGC Pediatrics)

Facility Use Only

MRN _____

PATIENT Name _____ Date of Birth _____
Last First MI

Address _____ Phone _____
Street City State Zip

Release records TO: **AGC Pediatrics, LLC**
204 Professional Court, SE
Calhoun, GA 30701 **Phone: 706-625-5900** **Fax: 866-751-8064**

*Receive **FROM** the following Person(s) or Organizations:*

Name: _____

Address: _____
Street City State Zip

Phone: _____ *Fax:* _____

Person *or Place that is requesting records:*

☐ Patient/Parent/Guardian ☐ Doctor/ Hospital ☐ Lawyer ☐ Insurance Company ☐ Other _____

Reason records are needed:

☐ Patient Care ☐ Disability ☐ Insurance ☐ School ☐ Legal ☐ Other _____

Release the records checked below, ☐ verbally ☐ on paper or ☐ electronically (if available)

☐ Visit/Discharge summary ☐ Lab results ☐ Surgery report
☐ Chart summary ☐ Radiology reports or ☐ Images on disc ☐ Billing records
☐ Emergency room report ☐ Doctor's office report (Doctor Name _____)
☐ Vaccination (shot) records ☐ Entire chart
☐ Pathology report ☐ Other _____

Treatment dates: _____

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