410 Peachtree Parkway, Suite 4260
Cumming, GA 30041
678-990-2501 (P)
678-990-2505 (F)
www.vickerypediatrics.com

Authorization for Release of Medical Information

Patients Name_____Date of Birth _____

Address_____City_____State_____Zip Code_____

Phone Number_____Date of Request_____

I authorize Vickery Pediatrics, LLC

TO RELEASE INFORMATION TO:

_____
Name of Provider or Facility Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

OR

I authorize Vickery Pediatrics, LLC

TO OBTAIN INFORMATION FROM:

_____
Name of Provider or Facility Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

PURPOSE FOR THIS REQUEST (check one) Transfer of Care ☐ Healthcare ☐ Insurance Coverage ☐

TYPE OF RECORDS REQUESTED (check one)

☐ Immunization History ☐ Medical Summary
☐ Complete medical record (Burned onto a disc; includes all visit notes, labs, immunizations, growth chart)
☐ Specific Treatment (select one or more, as applicable)

☐ Procedure Report ☐ History & Physical ☐ Physical Therapy ☐ X-Ray Reports ☐ Lab Results

AUTHORIZATION VALID FOR: (Check one)

☐ This request only.
☐ One year from the date of this authorization. This authorization applies to the records of the treatment received on or prior to the date of this authorization.

I UNDERSTAND THAT:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

Signature of Patient or Representative_____Date_____

Relationship to Patient (If requester is not the patient) _____