

## **Authorization for Release of Medical Information**

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

Patients Name	Date of Birth
AddressCi	tyStateZip Code
Phone NumberDate of Request	
I authorize Vickery Pediatrics, LLC	OR I authorize Vickery Pediatrics, LLC
TO RELEASE INFORMATION TO:	TO OBTAIN INFORMATION FROM:
Name of Provider or Facility Address	Name of Provider or Facility Address
City, State, Zip Code	City, State, Zip Code
Phone Number Fax Number	Phone Number Fax Number
<u> </u>	
PURPOSE FOR THIS REQUEST (check one)  Transfer of Care □ Healthcare □ Insurance Coverage □	
TYPE OF RECORDS REQUESTED (check one)	
<ul> <li>☐ Immunization History</li> <li>☐ Medical Summary</li> <li>☐ Complete medical record (uploaded on a USB drive; includes all visit notes, labs, immunizations, growth chart)</li> <li>☐ Specific Treatment (select one or more, as applicable)</li> </ul>	
☐ 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 adisclosure 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, theinformation 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) \_\_\_