



"Come grow with us"

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CONSENT TO RELEASE INFORMATION

Please transfer the medical records of:

Patient Name:

Date of Birth

Home Address _____

Home Phone: _____

Reason For Transfer _____

Release Information To:

Dr. or Practice Name: _____

Street Address: _____

City, State, Zip Code _____

Phone Number _____

Fax Number _____

***The initial transfer will be done as a courtesy- a fee will be assessed for any and all Subsequent transfers in accordance with GA statue (O.C.G.A.31-33-3)**

The signature below serves as authorization to transfer the records. I understand that these records may include psychiatric, chemical and substance abuse, HIV, and AIDS information, and that I may withdraw this authorization in writing, at any time, except to the extent that action has been taken based on this authorization. If patient is 18 yrs old, they may sign, otherwise parent's signature serves as authorization. The patient is ___my child(ren) ___Other ___.

Authorized Signature

Date

Print Name