north point pediatrics

"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

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