Eastman Pediatric Clinic

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Authorization to Release Medical Records

I hereby knowingly and voluntarily authorize

Eastman Pediatric Clinic at 1223 Plaza Ave, Eastman, GA 31023 / 33 S Ave, McRae, GA 31055

to release the following information to:

_____ at _____

(Provider/Guarantor Receiving Records) (Address of the Receiver)

Check any of the information that applies:

◯ All medical records ◯ Progress Notes Only ◯ Immunizations ◯ Early Intervention

◯ History and Physical / Growth Chart ◯ Diagnostic Test Results-Specify Type: _____

◯ Other (Specify): _____

Purpose(s) of this Release:

◯ Continuity of Care ◯ Personal Use ◯ Other (Specify): _____

This authorization expires on the following date or event: _____

I understand that this authorization will expire in *6 months* if no date is listed.

I understand that I have the right to withdraw this authorization in writing unless either of the following conditions exists:

_____ (receiving provider) has taken action in reliance on the authorization or if applicable, during a contestability period. If I want to withdraw this authorization, I understand that I must do so in writing an give it to:

_____ _____

(Name of Receiving Provider/Guarantor) (Address of Receiving Provider/Guarantor)

I understand that the information used or disclosed, because this form may be subject to redisclosure by the receiving health provider, may no longer be protected by privacy regulations. I also understand that I am under no obligation to sign this authorization and my ability to obtain treatment will not depend in any way on whether I sign this authorization.

_____ ___/___/___ ___-___-___

(Print Name of Patient) **(Patient Birthdate)** **(Social Security Number)**

Please Print Name of Patient or Legal Guardian: _____

Signature of Patient or Legal Guardian: _____ Date: _____

~~Please check one of the following:~~

These records are to be: ◯ PICKED UP ◯ FAXED (please provide fax number): _____

◯ MAILED (please provide a working address): _____