PRIMECARE PEDIATRICS
15A Baynard Park, Newnan, GA 30265
☎ Phone: (770) 251-5253; 🖷 Fax: (770) 251-5254

AUTHORIZATION FOR THE RELEASE OF PATIENT MEDICAL INFORMATION

[PLEASE COMPLETE ALL SECTIONS]

PATIENT'S NAME: *(Last, First, Middle Initial)*_____

ADDRESS:_____

City_____**State**_____**Zip Code**_____

DATE OF BIRTH:
_____

SSN:
_____

PHONE #:

PLEASE FAX RECORDS TO (770) 251-5254

I hereby authorize **PRIMECARE PEDIATRICS TO REQUEST** the following Medical Records/Health Information,

☒ **Coordination Of Care Records** *(Chart Summary, Medication History, Immunizations, Allergies),* | ***DATES OF INFORMATION REQUESTED:*** *[Please specify]*

From Date_____ ***To Date***_____

FROM:_____
[Name of Physician, Office or Facility]

Address:_____ _____ _____
Street *City* *State/Zip Code*

Tel: #:_____ **Fax #:** _____

Additional Information Requested, if any *(Please check box to indicate items to be released)* | ***DATES OF INFORMATION REQUESTED:*** *[Please specify]*

From Date_____ ***To Date***_____

☐ **All Medical Records** ☐ **Immunization Records** ☐ **Consultation Reports** ☐ **Genetic testing information**

☐ **Laboratory Results** ☐ **X-ray and Imaging Reports** ☐ **Psychological/Mental Health information** ☐ **Other** *(specify)*_____

The purpose of this release is *(check all applicable)*

☒ **Continuity of Care** ☐ **Change of locality** ☐ **Moved out of State** ☐ **At the request of parent/guardian** ☐ **Other** *(state reason)*_____

Medical Records Preparation Charges

In accordance with the provision of applicable law pursuant to O.C.G.A 31-33-3, PrimeCare Pediatrics, PC will charge a minimum fee of $5.00 for GA Form 3231 (Immunizations Records), Form 3300 (Hearing, Dental & Vision), and Form 3189 (College Immunization Form), and a minimum fee of $10.00 for forms that require a doctor's review such as, but not limited to, Sports, Camp, College, or Physical Forms. We charge a minimum fee of $25.00 for full medical records for the first request and a minimum fee of $15.00 for each additional requests (for the first ten pages), and $1.00 per page after that, per individual record requested.

If you need the requested information to be sent to a physician's office, as a courtesy to the physician, we will send the requested information at no charge.

All requests must be made by signing the proper form by an authorized party. In each instance, the applicable fee is due and payable on the day the request is made.

I am aware that some of the information in the requested Medical Record may be of a sensitive nature. By signing this release, I am granting permission for the information requested to be released. I waive any privileges or confidentiality existing under Federal or State Law regarding such information.
I understand that I do not have to sign this authorization in order to receive treatment from PrimeCare Pediatrics, PC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: PrimeCare Pediatrics, P.C., 15A Baynard Park, Newnan, GA 30265.
A fax or photocopy of this consent shall be considered as valid as the original.

X_____ **X**_____ **X**_____

Name of Parent/Legal Guardian (Photo ID Required) | **Signature of Authorized Person** | **Date**

*****If unable to sign, please document reason*****

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked in writing, this Authorization expires on_____ (insert applicable date).
If no date is specified or indicated, the Authorization will expire 90 days from the date of signing.

