

South Georgia Pediatric and Allergy Center, P.C.

3331 North Valdosta Road Valdosta, Georgia 31602
(229)-247-2211 – (229)249-9490 Fax

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(PRINT PATIENTS Full name)

(PATIENTS Date of Birth)

(Print name of Parent/legal guardian if under 18) (Day phone number w/area code)
Name and Address of Office/Hospital from whom your seeking Medical Records:

Telephone: _____

Fax: _____

Check One: I am the Patient (must be 18 or older)
 Parent
 Legal Guardian w/custody

Mail or Fax records to:

South Georgia Pediatric and Allergy Center
3440 North Valdosta Road
Valdosta GA 31602
Fax to 229-249-9490

- I place no limitations on history or illness (Including HIV and or AIDS, genetic, drug dependency or psychiatric information) or diagnostic and therapeutic information, including treatment for alcohol or drug abuse, or psychiatric disorders.
- I authorize the inspection of the above information by the above named agency.
- I understand that unless otherwise limited by state or federal regulations, I may withdraw this consent at any time by submitting my withdrawal request in writing.
- I hereby acknowledge that I have read or have had read to me, the above statements, and I fully understand the above statements and do expressly and voluntarily authorize the disclosure of medical information to the agency listed above.

Purpose of Release of Protected Health Information is:

- Transferring Physicians
 Continued Medical Care
 Legal Action/Review
 Insurance Requirement
 Other _____

This authorization expires in 6 months (12 months for school request) unless otherwise disclosed : _____

Authorizing Party : _____ Date: _____

Witness Signature: _____ Date: _____