Authorization for Release of Medical Information

______________________________ (Name of patient)   ______________ (Date of birth)

I, ______________________________, hereby authorize The Children's Clinic to release from my medical record the following information checked below:

___Complete Medical Record   ___Lab Reports

___Immunization Record   ___X-Ray Reports

___Other (please specify)______________________________

DATES OF TREATMENT: From ______________ To ______________

PURPOSE OR NEED FOR RELEASE (please check all applicable categories):

__Further medical care   __Disability Determination   __Referral

__Legal purposes   __Workmen's Compensation   __Life Ins.

__Other (please specify)______________________________

RELEASE INFORMATION TO: ______________________________
(Name of person)

____
(Group or Company)

____
(Street address)

____
(City)   (State)   (Zip code)

____
Signature of patient

____
Date

____
Signature of legal representative, patient is a minor or unable to sign

____
Relationship to patient

____
Reason patient cannot sign

Return completed release form to: **The Peachtree children's clinic**
5380 Peachtree Industrial Blvd, Ste 140
Norcross, GA 30071
Phone (770) 446-1818
Fax (770) 446-1808