The Pediatric Center of Stone Mountain, LLC
Medical Records Release – **INCOMING**

PATIENT INFORMATION:

First Name:	Middle Name:
Last Name:	Date of Birth:
Street Address:	City:
State:	Zip Code:

I, (full name of parent/guardian or self)_____ authorize

Name of Doctor, practice, facility or entity:	Address:
Phone Number:	Fax Number:

To release the following Medical information to:
The Pediatric Center of Stone Mountain, LLC
5405-D Memorial Drive, Stone Mountain GA 30083
PH: 404-296-3800 FAX: 404-296-1052

for the following purpose:_____

Please initial the line next to the appropriate request. (please initial **ONE**)

_____ All of my child's medical records (as of the date of this release)

_____ All of my child's medical records **except** the following: _____

_____ Only the following information: _____

(please turn over to complete this form)

Patient Name:	Date of Birth:

This authorization also Specifically allows the release of the following information (this information **WIL NOT** be released unless the appropriate line is initialed):

_____ Any record or treatment for alcohol/or other substance abuse

_____ Any Record of Mental Health Care (Evaluation, Testing, Treatment and Counseling)

_____ Any record of testing, treatment, reporting, or research pertaining to infection with HIV, any sexually transmitted or related disease, or pregnancy termination.

This release is effective for 1 year from the date of execution; however I may revoke it at anytime by providing notice in writing to the above named party.

I acknowledge that a completed copy of this release is available to me through the Patient Portal.

A copy of this form is acceptable authorization for the release of the above described information.

Notices to Person Authorizing Disclosure

Except for certain research purposes, the completion of this authorization is not required prior to the provision of treatment.

The information released pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state privacy laws.

Printed Name:
Signature:
Parent/Patient/Legal Representative/Officer of the Court Authorizing Disclosure
Date:
Relationship to Patient: