MEDICAL RECORDS RELEASE AUTHORIZATION FORM

To: Dr.: _____

(Name of Physician or Facility from whom your child(ren)'s Medical Records will originate)

Address: _____

Telephone No.: _____ Fax No.: _____

I _____, as Parent or Legal Guardian of the Child(ren) indicated below, do hereby authorize &/or grant permission to the above-named Physician, to release through fax or mail, the specified Medical Records of my child(ren) as follows: / / Immunization Records; / / Physician Encounter Notes; / / Med. Problems List; / / Growth Charts; / / Laboratory Tests Results; / / History & Physical; / / Others _____; / / All of the above.

(Please specify)

Child(rens) Name: 1) _____, _____ _____

(Last Name) (First Name) (Date of Birth)

2) _____. _____ __ _____

3) _____, _____ _____

4) _____, _____ _____

Please send all of the above indicated Medical Records to the Physician named below for the purpose(s) of: / / Continued care/treatment, / / Others _____.

(Please Specify)

Physician Receiving the Records: **LIRIO E. PALMOS, M.D., F.A.A.P.**

Dba: CARE-WELL PEDIATRICS, LLC

Address: 1546 10th Ave., Suite A, Columbus, GA 31901

Tel. No.: (706) 322-5526 Fax No.: (706) 322-1237

I understand that: a) I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation, b) my child(ren)'s treatment, payment of services, enrollment or eligibility for benefits, may not be conditioned on the signing of this authorization, c) the information described above may be re-disclosed by the recipient and may no longer be protected by the Federal HIPAA privacy regulations, d) the released records may contain communicable diseases, alcohol or drug abuse, psychological, psychiatric, HIV testing & results or AIDS information and, e) as per State of Georgia Regulations these records will be released within 30 days with an applicable copying & mailing fee. Likewise, when I want extra copy of these records, I may have them at a reasonable reproduction &/or handling fee, as per State regulation. **This authorization will expire in / / 6 months; / /12 months from the date I signed this authorization.**

Authorized By: _____ **Date:** _____

(Parent or Legal Guardian's Signature)

Witnessed By: _____ Date: _____