300 Dawson Commons Circle, Suite 320 · Dawsonville, GA 30534
Tel: (706) 216-2771 · Fax: (706) 216-2944

Authorization for Release of Medical Information

Patient Name____ **Date of Birth**_______________________

Patient Name____ **Date of Birth**_______________________

Patient Name____ **Date of Birth**_______________________

Patient Name____ **Date of Birth**_______________________

PARENTS: Please be advised, that if this form is not filled out completely, we will not be able to receive/release your child's medical records. Please include Practice Name, Address as well as, telephone and fax numbers. For **Newborns**, Please put the hospital at which they were born.

☐ *I authorize Dawson Pediatrics to* **Release Information TO**:

____
Name of Provider or Facility

____
Address

____
City, State, Zip Code

____
Phone Number *Fax Number*

OR

☐ *I authorize Dawson Pediatrics to* **Obtain Information FROM:**

____
Name of Provider or Facility

____
Address

____
City, State, Zip Code

____
Phone Number *Fax Number*

***Please indicate an expiration date for this release, by checking the appropriate box below:

☐ Expires_________________________ ☐ Does Not Expire

Reason for Transfer____

Please release all pertinent medical records on the above named child/children. Records should include all inpatient records, office notes, lab results and immunization records.
The signature below serves as authorization to transfer the records. I understand that these records may include psychiatric, chemical and substance abuse, HIV and AIDS information, and that I may withdraw this authorization in Writing at any time, except to the extent that action has been taken based on this authorization.

_____________________________________ _________________________
Parent/Guardian Signature *(unless 18 yrs or older)* **Date**