DAWSON PEDIATRICS
300 Dawson Commons Circle, Suite 320 · Dawsonville, GA 30534
Tel: (706) 216-2771 ·Main Fax: (706) 216-2944
Medical Records Fax: (706) 525-7422

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* **Obtain Information FROM:** **OR** ☐ *I authorize Dawson Pediatrics to* **Release Information TO:**

_____
Name of Provider or Facility

_____
Address *City, State, Zip Code*

_____
Phone Number *Fax Number*

☐ *Does Not Expire*

☐ *Expires:* ____/____/____ **Please indicate expiration date*

If transferring, please indicate reason for transfer: _____

Parent/Guardian Name & Phone Number: _____

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**