AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION:

Release of Medical Records

Patient Information (Please Print):

Name:_____ Date of Birth:_____
Name:_____ Date of Birth:_____
Name:_____ Date of Birth:_____
Name:_____ Date of Birth:_____
Name:_____ Date of Birth:_____

Phone Number:_____
Address:_____

Street City State Zip

PURPOSE OF DISCLOSURE:_____

Release Medical Records FROM:

_____ _____

Name/Institution: Name/Institution:

_____ _____

Address Address

_____ _____

City State Zip City State Zip

_____ _____

Phone Number Fax Number Phone Number Fax Number

Please release a copy of all my medical records, including but not limited to: progress notes, immunization records, laboratory results, and diagnostic tests.

Release Medical Records TO:

Whitney Williams, CPNP
Bloom Pediatrics, LLC
2151 Eatonton Road H2, Madison, GA, 30650
Tel: (706) 752 - 5153
Fax: (833) 764 - 0731

I understand that I have the right to revoke this Authorization at any time in writing to the practice at the address above. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits. I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

_____

Name (Print) Name (Signature) Relationship Date