<u>Authorization for Release of Medical Information</u>

Patient Name: ____

DOB: ____/____/_______

I, ______________________________ hereby authorize the release of medical information to:

All Starr Pediatrics, LLC
19 Eastbrook Bend, Suite 200
(678) 833-5199 office; (678) 519-1159 fax

FROM:
Doctor/Clinic/Hospital: ____

Address: ____

____

Telephone: _____________________________ Fax : _______________________

Please release the following:

___ **All health information (including growth charts and vaccination records)**

___ History/Physical Exam

___ Progress Notes

___ Discharge Summary

___ Consultation Reports

___ Diagnostic Test Reports

___ Radiology/Images

___ Lab Results

___ Pathology Reports

___Other (specify): ____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

___ Yes, I consent to the release of this information.

___ No, I do not consent to the release of this information.

Purpose of disclosure:

___ Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: ________________________________ Date: ____/____/____

Print Name: ________________________________

Relationship to Patient: ________________________