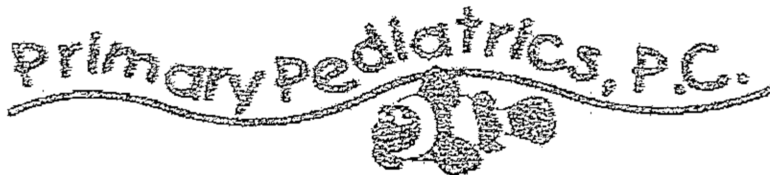

William Lee Tift, MD
Lance E. Slade, MD
Jill M. Waters, MD
Lindsay S. Kinnebrew, MD
Jason L. Smith, MD
Donna M. Payne, MD
Robert A. Ford, MD
Jessica T. Ford, MD
Gabriella R. Kacsoh, MD
Chris J. Cawley, MD
Joni D. Milner, CPNP

Authorization for Release of Health Information to Primary Pediatrics, P.C.

By signing this form, I authorize the organization named below to use, release, or disclose the protected health information described below to Primary Pediatrics, P.C.:

Organization PROVIDING the information:	Organization RECEIVING the information:
Name: ____________ Address: ____________ ____________ ____________ Phone Number: ____________	Primary Pediatrics, P.C. 550 Professional Drive Macon, Ga 31201

Purpose of disclosure (i.e. at the request of the patient, parent, guardian, employment, life or disability insurance, etc.): ____________

____

____________ authorize the following information to be sent to the address above:

____ Copies of all medical records for the period ___/___/___ to ___/___/___

____ Copies of all of the information described below for the period ___/___/___ to ___/___/___

____ History & Physical Examination ____ Lab, Radiology Reports

____ Reports from other physicians ____ Other (Please specify): ____________

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV) infection; behavioral health sexually transmitted diseases; service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should NOT be released, even if occurring during the dates above:

____

Please describe any special requirements such as faxing, certified mail, extended expiration date, etc.

I understand that Primary Pediatrics, P.C. assumes no responsibility for the use or misuse of by others of the health information disclosed under this authorization. I realize the information used or disclosed pursuant to this authorization may be subject to re-discolsure by the recipient and no longer be protected. I release Primary Pediatrics, P.C. from all legal liability that may arise from this authorization. I understand I may revoke this authorization at any time by submitting a written request to the practice.

Child's Name: ____________ Date of Birth: ____________

Parent/Guardian Signature: ____________ Date: ____________

Relationship to Patient (Required): ____________ Contact Phone Number: ____________

Forsyth
164 North Lee St.
Forsyth, Ga 31029
Exit 187 off I-75
Office (478) 994-6868
Fax (478) 994-6363

Macon
550 Professional Dr.
Macon, Ga 31201
Exit 164 off I-75
Office (478) 741-3007
Fax (478) 744-3481

Warner Robins
6084 Lakeview Rd.
Warner Robins, Ga 31088
Exit 147 off I-75
Office (478) 333-2270
Fax (478) 333-2273

McDonough
110A Regency Park Dr.
McDonough, Ga 30253
Exit 218 off 1-75
Office (770) 288-2285
Fax (770) 288-2284