



Truitt S. Boatright, MD  
 Jessica T. Ford, MD  
 Lindsay S. Kinnebrew, MD  
 Lance Slade, MD

Chris J. Cawley, MD  
 Robert A. Ford, MD  
 Jane Maddox, MD  
 Jason Smith, MD

R. Kim Coker, MD  
 Gabriella R. Kacsoh, MD  
 Donna Payne, MD  
 Jill M. Waters, MD

## **Authorization for Release of Health Information from 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.

Please transmit via: ☐ Fax, ☐ Mail, ☐ Pick Up

Pick up is not available for medical records (unless it is to get a Social Security card) Cost per child \$15, FMLA Forms \$25

**Date of Request:** \_\_\_\_\_

Organization PROVIDING the information:	Organization RECEIVING the information:
<p>Primary Pediatrics, PC          5300 Bowman Road          Macon, GA 31210</p>	<p>Name: _____          Address: _____          _____          Fax Number: _____</p>

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

I 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 \_\_\_\_/\_\_\_\_/\_\_\_\_
- ☐ General Paperwork (school, FMLA, etc.)
- ☐ History & Physical Examination      ☐ Lab, Radiology Reports
- ☐ WIC Form      ☐ Sports Physical Form
- ☐ Report from other physicians      ☐ Other (Please specify): \_\_\_\_\_

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, human immunodeficiency virus (HIV) infection, behavioral health 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 dates, etc. \_\_\_\_\_

I understand that Primary Pediatrics, P.C. assumes no responsibility for the use or misuse 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-disclosure by the recipient and no longer 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 Name: \_\_\_\_\_ Relationship (Required): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Macon	Warner Robins	Forsyth	McDonough	Bonaire
5300 Bowman Road	6082 Lakeview Road	164 North Lee Street	110A Regency Park Drive	104 Bluff Chase
Macon, GA 31210	Warner Robins, GA 31088	Forsyth, GA 31029	McDonough, GA 30253	Bonaire, GA 31005
Exit 164 off I-75	Exit 147 off I-75	Exit 187 off I-75	Exit 218 off I-75	Off US-129
Office 478.741.3007	Office 478.333.2270	Office 478.994.6863	Office 770.288.2285	Office 478.336.1980
Fax 478.744.3481	Fax 478.333.2273	Fax 478.994.6363	Fax 770.288.2284	Fax 478.744.3481