Azalea Pediatrics
Amy E. Brown, MD

Authorization for Release of Medical Information

Patient Name: _____ DOB: ____/____/_____

I, _____ hereby authorize the release of medical
(patient's name)
information **TO/FROM** (please circle one)**:**

Clinic: Azalea Pediatrics

Address: 6801 River Road Suite 401
Columbus, Georgia 31904

Telephone: (762) 208-5025 Fax : (706) 960-6957

TO/FROM (please circle one)**:**
Doctor/Clinic/Hospital:_____

Address: _____

_____

Telephone: _____ Fax : _____

Please release the following:
___ **All health information (including growth charts and vaccination records)**
___ History/Physical Exam ___ Discharge Summary ___ Diagnostic Test Reports ___ Lab Results
___ Progress Notes ___ Consultation Reports ___ Radiology/Images ___ Pathology Reports
___Other (specify): _____

Purpose of disclosure (circle one):
Treatment/ Continuing medical care Moving Aging Out Change of Insurance

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 of Parent or Legal Guardian: _____ Date: ____/____/____

Print Name: _____ Relationship to Patient: _____