Pediatrics at Brookstone Centre
2001 Brookstone Centre Parkway
Columbus, GA 31904
Medical Records Release Form
Phone: 706-571-9699 Fax: 706-571-9565

Patient: _____ DOB: _____

Release From: _____
Phone: _____ Fax: _____
Address: _____
_____

Release To: _____
Phone: _____ Fax: _____
Address: _____
_____

Record Requested: __ All Medical Records __ Dates: From _____ to _____
__ Shot Record __ X-Rays/ Labs

Reason for Records: __ Transfer of Care __ Disability __ Relocation

Records shall be delivered by: __ Pick-up __ Mail

By signing this authorization, I authorize the use and disclosure of my Protected Health Information as requested. I understand that the information may be re-disclosed by the recipient and may no longer be protected by the federal HIPAA privacy rule. I accept the responsibility for any fees that may be associated with this request.

A $25 charge for processing medical records may apply. Once record release has been signed, your child is considered "transferred" and no additional services can be provided by our office.

_____ _____
PARENT/GAURDIAN SIGNATURE **DATE**

Relationship to patient: _____ Date of Authorization: _____

This Authorization expires 90 days from date of authorization.