

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: _____

Release To: _____

Phone: _____ Fax: _____

Phone: _____ Fax: _____

Address: _____

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.