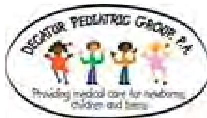

DECATUR PEDIATRIC GROUP, P.A.

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Clarkston, GA 30021

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Lithonia, GA 30058

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Smyrna, GA 30080

10246 Industrial Blvd
Covington, GA 30014

Telephone: 404-296-7133 **Fax: 404-296-7211** **Website: www.decpedgrp.com**

Medical Records and Health Care Information Release

Authorization for Use/Disclosure of Protected Health Information

I hereby request and authorize ____
to release, use or disclose Medical Records as described below:

Phone:____________________ **Fax**:_________________

______________________________ Patient's Full Name (Last, First, Middle Initial) ____________________ Date of Birth (mm/dd/yyyy)

______________________________ Current Address Apt. # ____________________ City / State / Zip

____________________ Driver's License # ____________________ Home Phone ____________________ Cell/Work/Other Phone

This Authorization applies to the following date(s) of Service: ____________________ (Leave Blank for All Service Dates)

State Requirements for Complete Medical Records

Search, Retrieval & Other Direct Administrative Costs	Up to:$25.88
Copying Costs for Records in Paper form	Per page for pages 1-20: $0.97
	Per page for pages 21-100: $0.83
	Per page for pages over 100: $0.66

Reason for Request to Release Records:
□ *Physician/Hospital/Therapist Request* □ *Moving from Area* □ *Other (Please Specify):______________*

Where would you like requested records sent?

Name: ____

Address ____

City ______________________ State/Zip______________

Phone ______________________ Fax ____________________

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. I further understand that this Authorization is specific to the information checked above, for the date(s) of service indicated, and for the purpose written above.

________________________________ Signature of Parent or Legal Guardian ____________________ Printed Name ______________ Date

Relationship to patient________________________________. If relationship is other than parent, documentation of legal authorization(s) or Guardianship must be attached to this authorization.

Update: 2/2/17