410 Peachtree Parkway, Suite 4260
Cumming, GA 30041
678-990-2501 (P)
678-990-2505 (F)
www.Vickerypeds.com

Authorization for Release of Medical Information

Patients Name _____ Date of Birth _____

Address _____City _____State _____ Zip Code_____

Phone Number_____ Date of Request_____

☐ I authorize Vickery Pediatrics, LLC
TO RELEASE INFORMATION TO:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

OR

☐ I authorize Vickery Pediatrics, LLC
TO OBTIAN INFORMATION FROM:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

PURPOSE FOR THIS REQUEST (check one) Transfer of Care ☐ Healthcare ☐ Insurance Coverage ☐

TYPE OF RECORDS REQUESTED (check one)

☐ Immunization History ☐ Medical Summary

☐ Complete medical record (Burned onto a disc; includes all visit notes, labs, immunizations, growth chart)

☐ Specific Treatment (select one or more, as applicable)

☐ Procedure Report ☐History & Physical ☐Physical Therapy ☐X-Ray Reports ☐Lab Results

AUTHORIZATION VALID FOR: (Check one)

☐This request only.

☐One year from the date of this authorization. This authorization applies to the records of the treatment received on or prior to the date of this authorization.

I UNDERSTAND THAT:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

Signature of Patient or Representative_____Date_____

Relationship to Patient (If requester is not the patient) _____