AUGUSTA PEDIATRIC ASSOCIATES

Joshua Coleman, MD · Jennifer Drake, MD · Aaron Hanna, MD
Josh Lane, MD · George Lazari, MD · Barbara Leverett, MD
Jennifer Massey, MD · Clark Newton, MD · Matthew Threadgill, MD

1245 Augusta West Pkwy, Augusta, GA 30909
3736 Mike Padgett Hwy Ste A, Augusta, GA 30906

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Best phone to reach you: (_____) _____ Secondary # (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

INFORMATION TO BE RELEASED FROM:

_____
Physicians / Practice Name

_____
Street Address

_____
City, State, Zip

Phone_____/Fax_____

RELEASE TO:

- ▫ Joshua Coleman, MD
- ▫ Jennifer Drake, MD
- ▫ Aaron Hanna, MD
- ▫ Joshua Lane, MD
- ▫ George Lazari, MD
- ▫ Barbara Leverett, MD
- ▫ Jennifer Massey, MD
- ▫ Clark Newton Jr., MD
- ▫ Matthew Threadgill, MD

INFORMATION TO BE RELEASED:

▫ Entire Medical Record ▫ Immunization Record ▫ Labs / X-Rays ▫ Mental Health (Includes ADD/ADHD)

▫ Single Visit - Date of Visit _____/_____/_____ ▫Other_____

PURPOSE OF RELEASE:

▫ Continuation of care ▫ Transfer to another provider ▫ Moving ▫ Other: _____

I understand that:

- The records released may include information relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.
- Authorizing the disclosure of this health information is voluntary. If I have questions about disclosure of my health information I can contact the authorized individual or organization making disclosure.
- I may cancel this authorization at any time by submitting a written request to the releasing practice.
- Any disclosure of information carries with it the potential for the further releases or distribution the recipient that may not be covered by confidentiality laws.
- If I authorize Augusta Pediatric Associates to release my records by email many email servers are not a secure means of communication, nor are they obligated to abide by HIPAA regulations that protect my health information. I hold Augusta Pediatric Associates harmless for any undesired results stemming from my request to receive medical records by email or by any other unsecure means.
- My signature below indicates that I am authorized to obtain/release records on the patient(s) indicated and there is no court order denying guardianship, parental rights, or authorization to obtain/release these records.
- This authorization will expire in 90 days.

Parents Name: _____ Phone Number:_____

_____ _____
Signature of Parent / Legal Guardian Date