**Authorization for Release of Medical Records**

I am requesting that the medical records for my child/children be transferred FROM:

Name or Previous Doctor

Address

City, State Zip

Phone Fax

I am requesting that the medical records for my child/children be transferred TO:

Duluth Children’s Medicine, PC

3500 Duluth Park Lane, Suite 220

Duluth, GA 30096-3230

(678) 878-2808 (phone) / (678) 878-2805 (fax)

The release of information to which I consent is for the purpose of:

I understand this authorization includes the release of all medical records including HIV records, mental health records, drug/alcohol abuse records, venereal disease and any other statutory protected diseases. This authorization will expire 90 days following the date signed unless otherwise noted. I understand that I may revoke this authorization and consent at any time except that the action has previously taken in reliance hereof. By signing this form, I am authorizing you to disclose protected health information about my child/children.

Signature of Patient or Legal Guardian

Date Expiration date

Patient’s Name Date of Birth

Patient’s Name Date of Birth

Patient’s Name Date of Birth

Patient’s Name Date of Birth