GI CARE FOR KIDS

993-D Johnson Ferry Road, N.E.
Suite 440, Atlanta, GA 30342
404-257-0799

Authorization for Release of Medical Information

Patient's Legal Name: _____
Address: _____
City/State/Zip Code: _____
Date of Birth: _____ Phone Number: _____
Date of Request: _____ **Date Needed:** _____

☐ I authorize GI Care for Kids
to obtain information FROM OTHER DOCTORS, HOSPITALS, ETC:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # (include area code)

_____
Fax # (include area code)

OR

☐ I authorize GI Care for Kids
to release information TO PARENTS, OTHER DOCTORS, ETC:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # (include area code)

_____
Fax # (include area code)

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

TYPE OF RECORDS REQUESTED: (check one)
☐ All medical records related to a specific illness or injury.

_____
Specify illness/injury Date(s) of treatment

☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
☐ Specific information (Select one or more, as applicable)
☐ Procedure report ☐ History & physical ☐ Laboratory test results
☐ X-ray reports ☐ Other _____
Please Describe
☐ Copy of the entire medical record, as allowed by law.

NOTE: AUTHORIZATION VALID FOR THIS REQUEST ONLY

I understand that:

- My right to healthcare treatment is not conditioned on this 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 disclosed.
- There will be a charge for the requested records. Doctors' offices will not be charged for requested records.
- Please allow 7-10 business days from the date of this request for records to be available for pick-up or delivery.

Signature of Patient or Representative _____

Relationship to Patient *(if requester is not the patient)* _____

PLEASE FAX BACK TO (404) 503-2249