Reddy Pediatrics

1061 Dowdy Road
Suite 202
Athens, GA 30606

Phone: 706-208-3715 Fax: 706-621-7557

AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL INFORMATION

Patient's Full Name: Date of Birth:

Parent/Guardian's Full Name: Phone:

Street Address: Email:

Request Information From: Release Information to:

Name of Company/Agency/Facility/Person Name of Company/Agency/Facility/Person

Street Address Street Address

City/State/Zip City/State/Zip

Phone/Fax Phone/Fax

Authorize release of information related to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse. Yes ____ No ____

Information Needed For: Attorney ____ Insurance Company ____ Self ____ Other

Complete Record : Yes _____ Partial Record _____
(Indicate information needed and date range, for example, MRI reports 2006)

There is a fee for reproducing patient records.

These fees are pursuant to Georgia Statute 31-33-3

$ 25.88 Search and Retrieval Fee, plus page fee as listed below:

.97 per page for pages 1 – 20
.83 per page for pages 21 – 100
.66 per page for pages over 100
$ 9.70 for certification fee (if applicable)

This information about the patient is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization

may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

Parent/Guardian's Signature Witness Date