McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough. GA. 30253

# AUTHORIZATION TO OBTAIN MEDICAL INFORMATION
## McDonough Pediatrics
### 101 Regency Park DR #140
### McDonough, GA 30253
### Phone: 770-957-8626 Fax: 770-957-7200

I authorize my child's Previous Doctor: _____

Street Address: _____

City, ST, ZIP: _____

To release to McDonough Pediatrics, PC the medical records for:

Patient's Name: _____ Date of Birth: _____

## *****PLEASE DO NOT FAX RECORDS IF OVER 15 PAGES*****

Information to be released: **Entire Record including Immunization Record**
By signing below, I understand that I:

- Am entitled to receive a copy of this authorization
- May inspect my records and that a fee of $25 may be charged for duplication and print out of records
- Am authorizing the disclosure of this health information voluntarily. I can refuse to sign this authorization.
- Have the right to revoke this authorization at any time, except to the extent that action has been taken based on this authorization.
- This authorization will expire, without my express revocation, 90 days from the request date specified below.

By Signing below, you are hereby authorizing McDonough Pediatrics to request/release the requested information.

Patient/Parent/Guardian Signature DATE

Signature of Witness DATE