Andrea V. Hill, MD
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Phone: 770-207-7916
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MEDICAL RECORD RELEASE AUTHORIZATION FORM

The following information is required by law before we can release the medical records of your child.

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY / STATE / ZIP: _____ PHONE: _____

I, the undersigned, hereby:

☐ Authorize **Monroe Pediatrics, Inc.** to release my Protected Health Information to the following person(s)/organization(s):

Name_____
Address_____
City / State / Zip _____
Phone: _____ Fax: _____

☐ Authorize _____ Fax: _____
(Primary Care Physician or Healthcare Provider)
to release my Protected Health Information to: **MONROE PEDIATRICS, INC., 517 GREAT OAKS DR. SUITE #103, MONROE, GA 30655**

Reason for Request (please check one):

☐ Transfer to another provider ☐ Legal Issues ☐ Appointment with specialist
☐ Personal Use ☐ Insurance Purposes ☐ Other _____

INFORMATION TO BE RELEASED

☐ Entire Record ☐ Immunization Record Only ☐ Laboratory Results Dated _____
☐ Other Specified Records _____
☐ Records generated by this office (ie: recent physical, shot/med record, growth chart, problem list, and routine labs) **including** HIV Test Results, Mental Health, Drugs, and Alcohol, and Psychiatric and Psychotherapy Treatment.
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Please Note: We do not copy information generated by other physicians / offices.

COPY FEE

1. I understand there is a charge for copying and handling my request. Per Georgia State guidelines, Monroe Pediatrics, Inc. has 21 business days to release your medical records.
2. Request for paper copies by patient/parent will be charged $0.10 per page with a minimum charge of $15.00 plus postage/shipping if mailed. Requests from other parties (ie: Attorney, Disability, Insurance Company, Personal Representative, etc.) will be charged as outlined: Parties requesting copies will incur a $20.00 charge for records retrieval plus $0.10 per page copied. If records are mailed, the actual shipping/postage charge will be incurred.

I authorize the release of copies of medical records and/or other information as noted above. If specifically indicated by me above I understand that this may include information concerning the following: psychiatric/psychotherapy records, mental health records, drug and alcohol treatment information, specific confidential HIV-related information, and/or any general physical condition information. I authorize this information be released by routine mail or pick-up. I understand that I may revoke this authorization at any time to the extent that the person who is to make the disclosure has already acted in reliance on this authorization. If not revoked earlier, this consent will remain in effect for one (1) year.

_____ _____
Signature of Patient or Parent/Guardian (if patient is under 18) Date

_____ _____
Print Name of Patient or Parent/Guardian (if patient is under 18) Relationship to Patient