Johns Creek Pediatrics

Consent for Release of Medical/Billing Information

Patients 18 Years of Age and Older

Patient Name (First): _____ (Last): _____

Date of Birth: _____/_____/_____ Patient's Email _____

Patient's Phone #: **(_____)** _____ **-** _____ May leave me a message ___YES ___ NO

I understand that I have the option to share or keep my chart and billing records confidential since I am 18 years of age or older and agree with the following:

_____ DO NOT Release any of my medical/billing information

OR

I hereby **consent** to the release of my medical/billing records to the following person(s):

Mother / Name: _____ Father / Name: _____

Other Person / Name: _____ Relationship to me: _____

The Records being released <u>should be limited to</u>: (Place Initials by Choices)

_____All Medical and Billing Records (if initialed, you don't need to initial the rest)

_____All Medical Records _____All Billing Records

_____Doctors/Progress Notes _____Immunizations records only

_____Laboratory or Clinical Results

_____Prescription History _____May request and pick-up Prescriptions for me

_____Other Limitations (Please explain): _____

PATIENT'S SIGNATURE _____ Date: _____

You may revoke or change this consent in writing at anytime.

(Office Use Only) Staff Member's Name: _____ Date: _____