



Johns Creek Pediatrics, PC
4395 Johns Creek Parkway, Suite 150
Suwanee, GA 30024
Phone: 770-814-1160
Fax: 770-814-1173

Medical Records Release Authorization

Patient name: 1) _____ DOB: _____

2) _____ DOB: _____

3) _____ DOB: _____

Please release the complete history and/or records in your possession concerning any treatment and services rendered. I hereby authorize the release of medical records to:

Johns Creek Pediatrics, PC
4395 Johns Creek Parkway, Suite A
Suwanee, GA 30024

Medical Records to be obtained from:

_____ Fax _____

By signing this authorization, I authorize the use and disclosure of my (child's) Protected Health Information as requested. I understand that the information may be re-disclosed by the recipient and may no longer be protected by the federal HIPAA privacy rule. I have the right to revoke this authorization in writing except to the extent that Johns Creek Pediatrics has already released the requested information. I understand that the medical records released to Johns Creek Pediatrics from another provider will become a permanent part of the patient's medical record.

Signature of parent or guardian: _____

Date: _____