Creekview Pediatrics
caring for your child from birth to 21 yrs
3925 Johns Creek Ct, Suite D
Suwanee, GA 30024
Phone: (770)-622-7742
Fax: (770)-622-7743

Authorization for Release of Medical Information

Patient's Name: _____ DOB: _____
Patient's Name: _____ DOB: _____
Patient's Name: _____ DOB: _____
Patient's Name: _____ DOB: _____

*****PLEASE FAX RECORDS TO 770-622-7743*****

I authorize Creekview Pediatrics to ***obtain*** information from:	***OR***	I authorize Creekview Pediatrics to ***release*** information to:
_____ Name of Provider or Facility		_____ Name of Provider or Facility
_____ Address		_____ Address
_____ City, State, Zip Code		_____ City, State, Zip Code
_____ Phone # Fax #		_____ Phone # Fax #

I am aware that if the medical record has information regarding substance abuse, mental health, communicable diseases, tuberculosis, or genetics, this information may be released ***unless indicated by checking here*** _____

Records Requested- Please Check One:
___**Medical Record**: All growth charts, recent labs, last well check/ office visit, all immunizations to date, and birth records. ___**Immunizations only** ___**Other** (Please Specify) _____

Purpose of Disclosure: __Move __Transfer of Care __ Insurance Change __ Personal __Legal

I authorize the release of medical information to another provider/facility as deemed necessary for my treatment. I further authorize Creekview Pediatrics, LLC, to obtain medical information from another provider/facility as deemed necessary in the course of my treatment. This authorization will expire in sixty (60) days from the date of signature and this authorization may be subject to re-disclosure and longer protection by HIPAA. My health care and payment for my health care will not be affected by refusing to sign this form. I understand that I may see and copy the information described on this form as requested. I may cancel this authorization at any time by submitting a written request to Creekview Pediatrics. I understand that the revocation will not apply to information that has already been released in response to this authorization. *I understand there is a fee for copying medical records.*

All records require at least 5 business days to process. To protect your privacy, the patient/legal guardian will be required to pick records up in person, and provide valid photo ID. Please provide phone number to be called when records are ready for pick up: _____

_____ _____ _____
Signature of Patient or Authorized Representative (Must be 18 Years or Older) **Name (Please Print)** **Date**