Just Us Kids Pediatrics

Authorization for Release of Medical Information

Patient Name:_____
DOB:_____/_____/_____

I, _____ hereby authorize the release of medical information to:
Just Us Kids Pediatrics
2462 Hwy 34 E Suite A
Newnan, GA 30263 770-683-5437

FROM:
Doctor/Clinic/Hospital:_____

Address: _____
_____

Telephone:_____ Fax:_____

Please release the following:

____ **All health information (including vaccination records)**
____ Lab Results ____ Vaccination Records
____ Radiology/Images ____ Other: _____

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.
Signature:_____ Date:_____
Printed Name:_____
Relationship to patient:_____