## OUR KIDS PEDIATRICS

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**AUTHORIZATION FOR RELEASE OF INFORMATION FORM**

Information obtained will be used only in the treatment of the patient and is confidential. This authorization includes but is not limited to school excuses, immunization records, parents work excuses, and WIC prescriptions.

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_

List of people or organization you wish to receive information. Please write your initials next to each organization that you grant us permission to release information regarding your child.

WIC \_\_\_\_\_\_\_\_ County of WIC Office \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Department \_\_\_\_\_\_\_\_\_ County of Health Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School \_\_\_\_\_\_\_\_ Name of School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day Care \_\_\_\_\_\_\_\_ Name of Day Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DFACS \_\_\_\_\_\_\_\_ County of DFACS Office \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent(s) Employer \_\_\_\_\_\_\_ Name of Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*THE FOLLOWING PEOPLE ARE AUTHORIZED TO BRING MY CHILD TO THE DOCTOR AND RECEIVE MEDICAL INFORMATION ABOUT MY CHILD’S CONDITION:*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESTRICTIONS**

If you are the CUSTODIAL PARENT of your child and you do not want your child’s protected health information given to the other parent (phone, verbal, or mail) please list the other parent’s name here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Please be advised that if you have joint legal or physical custody of your child, you CANNOT list the other custodial parent.

I authorize OUR KIDS PEDIATRICS to use or disclose my child’s health information the organizations or people I have listed above. I understand that this authorization is voluntary. I understand that I may also revoke any permission given to any listed organization at any time with a written and signed consent. You may refuse to sign this authorization. If you decide not to sign this authorization, please be advised that we CANNOT give out school/work excuses or immunization records.

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may cancel this authorization at any time in writing. Initials \_\_\_\_\_\_\_\_\_