PEDIATRIC CENTER FOR WELLNESS, P.C.
CONYERS, GA 30094
678-750-4000 OFFICE
678-750-4005 FAX

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ To release healthcare information of the patient named above to:

Name: PEDIATRIC CENTER FOR WELLNESS, P.C.

Address: 1506 KLONDIKE RD SW SUITE 205

City: CONYERS State: GEORGIA Zip Code: 30094

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

I understand that there may be information in these records that I would not want released. Below I have stated that information. I have been given a copy of Pediatric Center For Wellness's Notice of Privacy Practices and any charges that may be associated with this authorization. I have discussed all questions/concerns I have about the use, release, and disclosure of my health information with Pediatric Center For Wellness, P.C.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.