Kids First Pediatrics

Authorization for Release of Medical Information

I hereby authorize Kids First Pediatrics to transfer all of my children's medical records to:

Release Medical Records To: * (no CD's please)*

Kids First Pediatrics
143 Canal Street
Suite 500
Pooler, GA 31322
Phone (912) 748-4527
Fax (912) 748-9881

Release Medical Records From:

(Practice) _____
(Address) _____
City, State, Zip _____
(Phone) _____ (FAX) _____

Patient Name: _____
Date of Birth: _____

Information to be released:

Check here if PT was never seen/No records ☐

____ shot records
____ well baby check-up
____ sick visits
____ other: _____

Purpose or Need for Information:

____ transferring physicians
____ moving out of area
____ other _____

This consent will expire ninety days after the day below. I place no limitations on history of illness or diagnostic and therapeutic information including any treatment for alcohol, drug abuse, psychiatric disorders or acquired immune deficiency syndrome. This authorization can be revoked, but not retroactive to the release of information made in good faith.

Date: _____ Signature: _____

Witness: _____ Relationship: _____

Any disclosure of medical information by the recipients(s) is prohibited except when implicit in the purpose of this disclosure.
2009