All About Kids Pediatrics

Jill Overcash, MD, FAAP
Amanda Bennett, CPNP
2000 Riverside Parkway, Suite 207
Lawrenceville, GA 30043
Phone 678-646-0404
Fax 678-646-0202
www.allaboutkidsgeorgia.com

Medical Disclosure Form

By signing this form, I authorize All About Kids Pediatrics to release confidential health information about my child by releasing a copy of their medical record, a summary, or a narrative of their protected health information to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to the signed release form as follows:

- Complete Records
- Care Plans
- History and Physical
- Lab reports
- Treatment records
- Diagnosis'
- Progress Notes
- Medication records
- Other (please specify)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Fax: _____

_____

_____ _____

Parent/Legal Guardian Signature Date

Revised 01/01/2020

The above named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form
- This authorization will expire one year from the date the authorization is signed. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that is been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits.

Please Note

Unless otherwise specified by law, we release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, and/or other care facilities must be obtained directly from those providers or facilities.