CONYERS PEDIATRICS

1277B Wellbrook Circle, Conyers, GA 30012 770-922-5745 678-750-1406 fax
7138C Highway 212, Covington, GA 30016 770-788-1554 678-750-1406 fax

AUTHORIZATION FOR AND CONSENT TO RELEASE INFORMATION TO CONYERS PEDIATRICS

I, the undersigned patient/guardian, hereby authorize _____

to release information listed below from the records of _____,

date of birth _____ to Conyers Pediatrics.

The release of information for which I consent is for the purpose of _____

____ _____

for the following dates of office or outpatient services:_____

_____.

I understand this authorization includes release of all medical records including HIV records, psychiatric mental illness, drug/alcohol abuse records, venereal disease and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent of action previously taken in reliance hereof.

_____ _____
Parent or Guardian Signature Date Signed

_____ _____
Witness Date Signed