Columbus Pediatric Associates

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Authorization for use / Release of Health Information

Please check how you would prefer your records to be released from Columbus Pediatric Associates.

☐ A $5.00 Charge is payable at time of request for medical records to be **mailed from this office. ($____staff int. paid)**
☐ **No charge for a records summary copied,** you will be notified when ready to pick up. List a phone number to be contacted ____ / ____ / _____

Please Note: For CPA medical records we will provide one copy of your child's records at no charge to the parent. After one copy has been provided, any additional request for records will require a minimum fee of $25.00 per child's records. Once the records have been signed, you are considered **"TRANSFERRED"** and no longer an active patient in our practice. No additional services will be provided. Please be advised this office will not release information received from another practice of any type. You will need to contact those practices for records.

"COMPLETELY FILL OUT ENTIRE FORM'

I, _____ (relationship to patient) Parent or Guardian or Patient (circle one)

☐Hereby request medical records for the child(red) listed below to be **RELEASED FROM: Columbus Pediatric Associates to: (List complete address)**

_____

☐Hereby request medical records for the child(ren) listed below to be **OBTAINED FROM**: Hospitals, Labs, Pharmacies or Physician offices.

(List complete address of previous physician or fax number)

_____

Send Records to: Columbus Pediatric Associates, 1800 10th Avenue Suite 100-F Columbus, Ga. 31901 or fax to 706-221-4620

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PATIENTS FULL BIRTH NAME AND DATE OF BIRTH

1._____ 3._____

2._____ 4._____

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The adults named below are allowed for us to Consent for Medical Treatment and or Sign for medical records:

1. _____ # _____Relationship _____
2. _____ #_____Relationship_____
3. _____ #_____Relationship_____

Please indicate the reason for obtaining records:

☐ Moving out of area, List new address _____

☐Patient's Age

☐ Insurance

☐Other-Please explain briefly _____

X _____ / /

Signature of Parent / Legal Guardian / Patient of legal Age (18) **Date Signed**

THIS AREA IS FOR STAFF ONLY Records mailed _____ Call placed for records to be picked up _____ Staff Int. _____