JONESBORO PEDIATRICS

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Date Received:_____ Chart #:_____

Release Records To:

_____ Jonesboro Pediatrics
236 Arrowhead Blvd
Jonesboro, GA 30236
PH: 770-478-9240
FAX: 770-478-0318

_____ Jonesboro Pediatrics
210 W Campground Rd
McDonough, GA 30253
PH: 678-916-4010
FAX: 678-916-4014

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

I, _____, authorize and request:

_____
Name of Physician or Office Fax

_____
Address City State Zip

To Release: ___Office Notes ___Physical Reports ___Lab Reports ___Pathology Reports
___Ultrasound Reports ___All Records ___Other_____

Reason for Release:_____

Medical Records Copying Charges

The Georgia Office of Planning and Budget (OPB) pursuant to O.C.G.A. 31-33-3, calculates an annual inflation adjustment for the costs related to medical record retrieval, certification and copying. Payment for all requested information is due prior to release/disclosure. Fees for requested information are as follows:

- $25.88 for the search, retrieval and administrative costs related to the request for documents.

I am aware that some of the information in the requested Medical Records may be of a sensitive nature. By signing this release, I am granting permission for the information pertaining to the below mentioned areas to be released. I waive any privilege or confidentiality existing under Federal or State Law regarding such information, including, but not limited to ,protection afforded to:

- Communications made to a Psychiatrist (O.C.G.A 24-9-21)
- Communications made to a Licensed Applied Psychologist (O.C.G.A. 43-36-16)
- Medical information concerning drug dependency (O.C.G.A. 26-5-17)
- Medical information concerning alcohol and drug dependency (O.C.G.A. 37-1-166)
- Medical information regarding mental illness (O.C.G.A. 37-3-166)
- Medical information concerning mental retardation (O.C.G.A 37-4-126)
- Medical information concerning alcohol and drug abuse (42-C.F.R. Part 2)
- AIDS confidential information (O.C.G.A. 31-22-9 and 24-9-47)

This Authorization and Consent is in effect for 1 year. Our office will act on this release within 7-10 business days of receipt. The Authorization will terminate 1 year from the date appearing below. By signing below I am hereby authorizing Jonesboro Pediatrics to receive/release protected health information identified above. I also acknowledge that Jonesboro Pediatrics participates in e-prescriptions and authorize JPC to exchange (receive and send) the above patient's medication and prescription information with pharmacies and other healthcare entities.

Patient Name:_____Date of Birth:_____Last four of SSN#: XXX-XX-_____

Signature of Patient of Authorized Person:_____ Date:_____

Witness Signature:_____ Date:_____

Note to Recipient: The information that has been disclosed to you is or may be protected by State and Federal Law. You are prohibited from making any further disclosure of this information unless further authorization is obtained or disclosure is otherwise permitted by law. A General authorization for release of information may not be sufficient.