Children's
WELLNESS CENTER
COMPREHENSIVE PEDIATRIC CARE
5883 Glenridge Drive, Suite 100
Atlanta, Ga. 30328
Phone (404) 303-1314
Fax (404) 303-1399

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize Children's Wellness Center to release the health information of the individual named below:
   a. Patient Name _____
   b. Address _____
   c. Phone # _____DOB: _____
2. I authorize the information to be disclosed to and used by the following individual or organization:

   Physician Name_____

   Full Address _____

3. The type and amount of information to be disclosed is as follows: (specify dates if needed)
   a. ____ Immunizations and Growth Chart
   b. ____ Immunizations, Growth Chart, Last Well Child Check, Medicine List, & Problem List
   c. ____Abbreviated Medical Records
   d. ____ Entire Medical Record
   e. Please specify reason for disclosure: _____
   f. If transferring, please state reason(s) why: _____
4. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
5. I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
6. Children's Wellness Center, LLC cannot condition treatment, payment, enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re- disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of patient/ parent / legal guardian Date

_____
Relationship to patient