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

Request For Protected Health Information from Outside Provider/Source to CWC

Patient Name: _____ DOB: _____

1. I authorize the following organization to release the health information of the individual named above:
   a. Office Name: _____
   b. Address _____
   c. Phone # _____Fax #: _____
2. I authorize the information to be disclosed to and used by the following individual or organization:

Children's Wellness Center
Attn: Medical Records
5883 Glenridge Drive, Suite 100 Atlanta, GA 30328
Fax: 404-303-1399
** Faxing is preferred method to receive records

3. The type and amount of information to be disclosed is as follows: (specify dates if needed)
   a. ____ Entire Medical Record Inclusive Dates Only ___/___/___ through ___/___/___
   b. ____Immunization Records
   c. Please specify reason for disclosure: _____

I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section titled "Release Information To". I understand that the information to be released may include information regarding Psychological or psychiatric conditions, Drug and Alcohol usage, and AIDS/HV related information. I understand that once this information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law my refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits.

I understand that I may revoke this authorization at any time. This authorization will expire on _____. Specify an expiration date, if blank this form will expire in one year.

If patient is 18 years of age or older, the patient must sign and date the form.

_____ _____ _____
Printed Name Date Phone Number

_____ _____
Signature of patient/ parent / legal guardian Relationship to patient