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YOUTHCARE
child and adolescent medicine

Please fax or mail information to:

YouthCare Pediatrics of Central GA
233 N. Houston Road, Suite 140H
Warner Robins, GA 31093

(Fax) 478-923-9977
(Phone) 478-923-3360

Authorization To Release Health Information

____ Release Information to YouthCare

____Release Information from YouthCare

TO: _____

_____

_____

_____

RE: _____
(Patient's Name)

_____
(Date of Birth)

_____
(Name of Guardian)

_____
(Contact Phone Number)

Health information requested: ___all office records ___shot record ___other_____

Purpose for request: _____

PLEASE READ: I understand my first request for copies will be complimentary. However, any copies requested thereafter will be charged a fee. I also understand that these records may contain specific conditions which would be considered personal and private. I may withdraw my authorization at any time but not retroactively. If not revoked by me, this authorization will expire in 90 days, or on the following date, event, or condition. YouthCare will use the above information to contact guardian by telephone to pick up received copies. Two attempts will be made; however, copies will be shredded if not picked up within 90 days. A fee will be assessed for a second request. I have read YouthCare's policy and comply by signing:

_____ _____
(Signature of Guardian and Relationship to Patient) (Date)

_____ _____
(Witness) (Date)

----------YouthCare Office Use Only----------

Phoned to P/U #1 _____
Phoned to P/U #2 _____
Documents P/U _____