AUTHORIZATION FOR AND CONSENT TO
RELEASE INFORMATION

To: _____

_____
address

_____
city state zip

I, the undersigned patient/guardian, hereby authorize

LAWRENCEVILLE PEDIATRICS, P.C.
980 Highway 29 South
Lawrenceville, GA 30045 (770) 962-8025

to release information listed below from the records of

_____.

The release of information to which I consent is for the purpose of

_____.

I understand this authorization includes release of all medical records including HIV records, Psychiatric Mental Illness, Drug/Alcohol abuse records, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance hereof.

_____ _____
Signature of Patient/Guardian Date of Signature

_____ _____
Relationship to Patient Signature of Witness

AUTHORIZATION WILL EXPIRE ON
_____ (date)