Anthony P. Moreschi M.D., P.C.
PEDIATRICS
811 S Isabella Street Ste. C Sylvester, GA 31791
P:229-776-7060 F:229-299-4217

AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL INFORMATION

Patient Name: ____

Date of Birth: __________________ SSN: ____________________

Patient Address:

____

____

By signing below, you hereby auhorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to expect and copy the protected health information.

Information to be requested (please circle):

Medical Records Shot Records Complete Chart Lab/X-ray

The name of other specific informtation of the person(s) or class of persons to whom the practice may make the requested use or disclosure:

Dr. Anthony P. Moreschi M.D., P.C PEDIATRICS

***This information about you is protected by federal law and you have the right to revoke this authorization in writing. You may refuse to sign the authorization.

Patient signature of Personal Representative: __________________________

Date: ______________________________

As a personal representative, I have the authority to act for the individual because I am (please circle): Mother / Father / Guardian

Physician/Practice Name: ____

Telephone Number: ______________________ Fax: ____________________