SAVANNAH
INTEGRATIVE PEDIATRICS

Request for release of medical records:

Physician Name: _____
Address: _____
City: _____ State: _____ Zip: _____

I hereby request that the medical records for:
Patient's Name: _____ DOB: _____
Patient's Name: _____ DOB: _____
Patient's Name: _____ DOB: _____
Patient's Name: _____ DOB: _____

REASON FOR THE REQUEST: _____
The following information is to be disclosed: check the box(es) that apply
☐ All medical records ☐ Immunization Records ☐ Lab Results
☐ Daycare Forms ☐ X-rays ☐ Sports/Camp Forms
☐ Other
Be released to: Sommer Ferreira, CPNP-PC
Charmaine Pham, NP-C

Mail to: Savannah Integrative Pediatrics
Suite 201
132 Stephenson Avenue
Savannah, Ga. 31405
(912)567-3700 Office
(912)567-3701 Fax

Sensitive Information: I understand that the information in my record may include information in relation to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavior or mental health services or treatment for alcohol and drug abuse.
Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by the federal confidentiality rules.
Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.
Other Rights: I understand that I may refuse to sign this authorization and it is strictly voluntary. I do not need to sign this form to assure treatment. I also understand that I may inspect and obtain a copy of the information to be used or disclosed for a reasonable fee.
Expiration Date __/__/___ Unless otherwise revoked, this authorization will expire on this expiration date.

*Please do not fax records that exceeds 15 pages. Thank you.

Parent Legal/Guardian Signature: _____ Date: _____