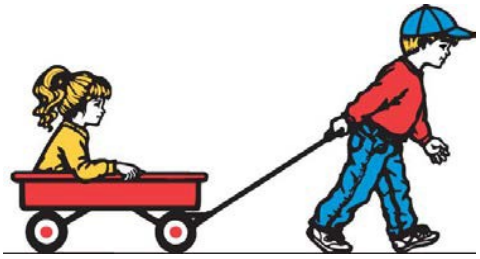

Pediatric Associates, PC

ROBERT M. LICATA, M.D., F.A.A.P. MARYGRACE ANI, M.D., F.A.A.P. GAIL PIKHOLZ, M.D., F.A.A.P.

CONSENT TO RELEASE MEDICAL INFORMATION

DATE_____

PATIENT NAME_____**DOB**_____

PATIENT NAME_____**DOB**_____

PATIENT NAME_____**DOB**_____

PATIENT NAME_____**DOB**_____

PLEASE FORWARD THE INDICATED MEDICAL RECORDS LISTED BELOW TO:

_____

_____

_____

There is an administrative fee of $25 per chart to copy records.

- □ **Vaccine Records Only (no charge)**
- □ **Complete Chart**
- □ **Behavioral Health**
- □ **OTHER** _____

PARENT/PATIENT (18+ YEARS OLD) NAME_____

PARENT/PATIENT (18+ YEARS OLD) SIGNATURE_____

PHONE NUMBER_____

REASON FOR TRANSFER OF RECORDS_____

Disclosure of Sensitive Information

I understand that my health record may contain sensitive information relating to patient's conditions. This includes, but is not limited to, information pertaining to sexually transmitted disease, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), behavioral or mental services and treatment for alcohol or drug abuse.

☐ I choose to **exclude** the above types of information from this disclosure.

2863 Johnson Ferry Rd. Ste 100 Marietta, GA 30062