

**TLC Pediatrics**

22335 U.S. Hwy 72 East, Ste C, Athens, AL 35613  
256-870-4111

**Authorization for Release of Protected Health Information**

To be completed by the patient or the patient's representative

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**I hereby authorize the transfer of my confidential health information**

**From:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone #/Fax #

**TO:**

TLC Pediatrics  
22335 U.S. Hwy 72 East, Ste C  
Athens, AL 35613  
256-870-4112

**Method of Transfer**

Copies by Mail

Copies by Fax

Copies to be picked up

**List of Records to be Transferred:**

Medical

Immunizations

Mental Health

X-Ray

Lab Reports

All Records

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent of Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Parent or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient