BEHAVIORAL PEDIATRICS of Rural Georgia

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth:_____

I request and authorize _____ to release healthcare and educational information of the patients named above to:

Michelle Zeanah, MD at Behavioral Pediatrics of Rural Georgia

EHR direct messaging: Zeanah.valantdirect.com

Via CD: 406 Savannah Ave., Statesboro, GA 30458

FAX: 912-681-4379

This request and authorization apply to:

- ☐ Healthcare information relating to the following treatment, condition or dates listed below.

  _____

- ☐ First mental health/behavioral/developmental office visit, growth chart (with BMI), psychological testing results, last 3 office visits and any recent lab results.
- ☐ All healthcare information
- ☐ Other

Please send before patient's appointment on _____. Thank you!

Parent/Guardian Signature: _____

Date: _____