For pediatric patients please include a current shot record.

JENNIFER MADON M.D.
101G W. NORTHSIDE DRIVE
VALDOSTA, GA. 31602

HIPPA Authorization for Release of Protected Health Information Form

Date _____ Date of Birth _____

First Name _____ Middle Name _____ Last Name _____

Address (City, St, Zip) _____

_____

Home Number _____ Work Number_____ Cell Number _____

I authorize the release of my Protected Health Information voluntarily by the person(s) named below:

PHI requested from _____

Address, City, State: _____

Phone Number _____ Fax Number: _____

PHI maybe released to _____

Address, City, State: _____

Phone Number: _____ Fax: _____

Receipt of Records: Pick Up: _____ Mail: _____ Fax: _____

Purpose for releasing protected health information (Please choose one).

_____ Transferring Physician

_____ Referral for Continued Medical Care.

_____ Legal Action

_____ Insurance Requirements

_____ Moving (provide date of move) _____

Other: _____ (Please Specify)

Insurance Information

Primary _____ Secondary _____

Have you previously been a patient of Dr. Madon's? (please circle one) YES or NO

Reason for leaving: _____ Date: _____

Signature of Authorizing Party _____ Date: _____

Print Signature _____

Relationship to Patient _____

Witness Signature _____ Date: _____

In Office Only:

Dr. Madon:

Accepted _____ Declined _____

Comments:

Payment Received By:_____

Circle Method of Payment: Cash Check Credit Card

Check or CC Trans #:_____