



LEAD SAFE ATLANTA

Record Release Form

I, _____, allow the FULTON COUNTY HEALTH

DEPARTMENT to: (Check both) RELEASE TO: _____ OBTAIN FROM: _____

City of Atlanta Lead Program

477 Windsor Street, Suite 101

Atlanta, GA. 30312

The following information: Results of all blood lead tests performed from the child's date of birth until the expiration date of this authorization (one year from the date of signature).

Reason: To use as criteria for accepting my family into the Lead Safe Atlanta Program.

I understand that I can take back this permission unless the information has already been given out. To take back the permission, I must send a letter to the Health Department program listed at the top of this page. Any records given out using this signed permission may be sent somewhere else by the agency we give it to. If they send it on, it may not be protected by the same laws.

You will not be refused any care by the Fulton County Health Department if you decide not to sign this form. The line below lists anything that will not be given out.

I understand that a copy of this can be used the same way as this form.

This permission ends one (1) year from the date signed by the (client/patient/parent/guardian).

(Client/Patient/Parent/Guardian) Witness

Date

Relationship to Child

Date