

**Authorization for Release of Health Information**

This form applies only to the release or disclosure of your health information. It is not consent for treatment and is not intended for any other purpose.

By signing this form, I authorize the release or disclosure of the protected health information (PHI) described below

**To:** Name -  
Address -

**From:** Name -  
Address -

Please give reason for transfer: \_\_\_\_\_

**NOTE: This authorization expires upon fulfillment of request. Information will not be resent without another signed authorization.**

Patient's Full Name (Printed): \_\_\_\_\_

DOB: \_\_\_\_\_

**\*\*\*\*Our office does require at least one week's notice to copy medical records. For pricing please see the Georgia State Copy Law on the reverse side\*\*\*\***

I authorize the following information to be sent to the address above:

- |  |             |
|--|-------------|
| ___ Copies of all records for the period           | ___/___/___ |
| ___ Copies of the information described below from | Mo Day Year |
| ___ Problem list & Vaccine Record                  |             |
| ___ History & Physical Examination                 | To          |
| ___ X-ray reports                                  |             |
| ___ Lab reports                                    | ___/___/___ |
| ___ Other (Please Specify)                         | Mo Day Year |

I understand that the records to be used or disclosed pursuant to this authorization may contain \_\_\_\_\_ records relating to information of personal medical nature and may include any history of or references to Acquired Immunodeficiency Syndrome (AIDS); Sexually Transmitted Diseases (STDs); Human Immunodeficiency Virus (HIV) infection; behavioral health; treatment for alcohol and/or drug abuse; or similar conditions.

I have been provided a copy of Children's Medicine, P.C.'s Notice of Privacy Practices and am aware that there are charges for copies of records made pursuant to this authorization. I have discussed any concerns I may have about the release or disclosure of my health information with Children's Medicine, P.C.'s Privacy Officer or the appropriate office personnel.

I understand that Children's Medicine, P.C. assumes no responsibility for the subsequent use/misuse by others of my health information which was disclosed under this authorization. I release Children's Medicine, P.C. from all legal liability that may arise from release of my information under this authorization.

The patient or their representative may revoke this authorization by notifying in writing to Children's Medicine, P.C.'s designated Privacy Officer or appropriate office personnel. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule under "HIPAA". Federal law also requires a statement that there is the potential that the protected health information released under this authorization may be subject to re-disclosure by the recipient. Any such re-disclosure is beyond the control of Children's Medicine, P.C.

**Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_  
(Parent or legal guardian)

**Date:** \_\_\_\_\_

**Fax Number:** Lawrenceville - (770) 935-6473

Buford - (770) 614-7369

Suwanee - (770) 406-2550

Georgia State Copy Law  
Section 2: Code Section: 31-33-3

The party requesting the patient's records shall be responsible to the provider for the reasonable costs of copying and mailing the patient's record. The actual cost of postage incurred in mailing the requested records may also be charged, in addition copying costs for a record which is in paper form shall not exceed \$0.97 per page for the first 20 pages of the patient's records which are copied. \$0.83 per page for pages 21 through 100 and \$0.66 for each page copied in excess of 100 pages. All of the fees allowed by this code section may be adjusted annually in accordance with the medical component of the consumer price index. A charge of up to \$25.88 may be collected for search and retrieval and other direct administrative costs related to compliance with the request under this chapter. If applicable, there may also be a charge of \$9.70 for a certification fee.

Pages 01-20 \_\_\_\_\_ # of pg. @ \$0.97 cents ea. = \$ \_\_\_\_\_

Pages 21 – 100 \_\_\_\_\_ # of pg. @ \$0.83 cents ea. = \$ \_\_\_\_\_

Pages 101 – up \_\_\_\_\_ # of pg. @ \$0.66 cents ea. = \$ \_\_\_\_\_

Total number of pages = \_\_\_\_\_

Subtotal for copies = \$ \_\_\_\_\_

Search retrieval & admin @ \$25.88 = \$ \_\_\_\_\_

Certification fee (if applicable) @ \$9.70 = \$ \_\_\_\_\_

Postage \$ \_\_\_\_\_

Total Due \$ \_\_\_\_\_

Name of Provider: Children's Medicine, P.C.

Address: 1500 Peachtree Industrial Blvd., Suite 250, Suwanee, GA 30024

Client's Name: \_\_\_\_\_

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**FOR OFFICE USE ONLY**

Prepared by: \_\_\_\_\_  
(Staff Member Signature)

Date sent out: \_\_\_\_\_