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
____ Problem list & Vaccine Record
____ History & Physical Examination
____ X-ray reports
____ Lab reports
____ Other (Please Specify)

___/___/_____
Mo Day Year

To

___/___/_____
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: _____ **Date:** _____
(Parent or legal guardian)

Fax Number: **Lawrenceville - (770) 935-6473** **Suwanee – (770) 406-2550**