

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

PATIENT NAME: _____ D.O.B: _____

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I hereby authorize:

**Pediatrics and Genetics
3586 old Milton Pkwy
Alpharetta, GA. 30005**

TO DISCLOSE THE ABOVE NAME INDIVIDUAL'S HEALTH INFORMATION AS DESCRIBED BELOW:
DATE(S) OF SERVICE REQUESTED (IF KNOWN) OR PROVIDER: _____

DESCRIPTION OF INFORMATION TO BE RELEASED: (CHECK ALL THAT APPLY):
 IMMUNIZATION RECORD RADIOLOGY /IMAGING REPORTS MOST RECENT HISTORY & PHYSICAL
 RADIOLOGY FILMS LABORATORY REPORTS CONSULTATIONS
 Progress Notes Entire Medical Record Other _____

I UNDERSTAND THAT THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATING TO COMMUNICABLE DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME ("AIDS"), OR HUMAN IMMUNODEFICIENCY VIRUS ("HIV"), BEHAVIORAL OR MENTAL HEALTH, ALCOHOL/DRUG (SUBSTANCE) ABUSE OR ANY SUCH RELATED INFORMATION.

THIS INFORMATION MAY BE DISCLOSED TO AND USED THE FOLLOWING INDIVIDUALS OR ORGANIZATIONS:

Practice Name: _____
Phone: () ____ - ____ **Address:** _____
Fax: () ____ - ____ _____

DESCRIPTION OF THE PURPOSE OR THE USE AND/OR DISCLOSURE:
 CONTINUING CARE SECOND OPINION SOCIAL SECURITY
 CONSULTATION INSURANCE
 LEGAL PURPOSES PERSONAL USE

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION. I FURTHER UNDERSTAND THAT MY HEALTH CARE AND THE PAYMENT OF MY HEALTH CARE WILL NOT BE AFFECTED IF I DO NOT SIGN THIS FORM. I UNDERSTAND I MAY INSPECT OR COPY THE INFORMATION TO BE USED OR DISCLOSED. I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THE AUTHORIZATION MAY BE SUBJECT TO DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL AND STATE PRIVACY REGULATIONS.

SIGNATURE OF PATIENT'S REPRESENTATIVE

DATE

PRINTED NAME OF PATIENT'S REPRESENTATIVE

OR

RELATIONSHIP TO PATIENT
SUPPORTING DOCUMENTATION)

LEGAL AUTHORITY (ATTACH
