

Pediatric Associates

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Policy 3.3

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (AUTHORIZATION TO RELEASE MEDICAL RECORDS)

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I hereby authorize the use/disclosure of my protected health information as described below:

1. The information that may be used / disclosed is the following:

- All of my protected health information including privileged information (HIV/AIDS<psychological, drug/alcohol information
 All of my protected health information with the exception of privileged information (as described above)
 Other (describe in a specific and meaningful fashion: _____

2. The information will be used / disclosed for the following purposes: **Transfer records to Pediatric Associates**

3. Persons / organization to use / **disclose** the information (check one):

Name of Practice: _____ Street Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: _____ Fax: _____

4. Persons / organizations authorized to receive the information:

Pediatric Associates, 1485 Jesse Jewell Pkwy, Suite 200, Gainesville, GA 30501

5. This authorization will expire (check one):

- 90 days from the date of signing
 When I revoke this authorization in writing as described below
 Other expiration event that relates to you for the purpose of the use / disclosure
 Other (specify date) _____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

Signature of Parent / Guardian

Date

Print Name of Parent / Guardian

Date