PEDIATRIC HEALTH CENTER
AUTHORIZATION FOR USE/RELEASE OF
HEALTH INFORMATION

By signing this form, I authorize Pediatric Health Center to Use, Release or Disclose the Protected Health Information described below:

Name of Person and/or organization to whom information should be sent:

PEDIATRIC HEALTH CENTER
4243 Dunwoody Club Drive, Ste 103
Dunwoody, GA 30350
678-336-5255 Office 678-336-5259 Fax

Please send this information on:

(PATIENT'S NAME AND DATE OF BIRTH)

(ADDRESS)

(TELEPHONE NUMBER) **(DATE)**

Purpose of Disclosure: _____

Expiration Date: _____

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

___ COPIES OF ALL MEDICAL RECORDS FOR THE PERIOD OF ____ TO_____
___ COPIES OF THE INFORMATION DESCRIBED BELOW FOR PERIOD ___ TO___
___ HISTORY & PHYSICAL EXAM. _____ LAB, X-RAY, ETC. REPORTS
___ REPORTS FROM OTHER PHYSICIANS
___ OTHER (PLEASE SPECIFY) _____

I understand that this information may include a history of AIDS, Sexually Transmitted Diseases, HIV Infection, Behavioral Health Service/Psychiatric Care, Treatment for Alcohol and/or Drug Abuse, or similar conditions.
The following should not be released, even if occurring during dates above:

_____

I understand that there may be information in these records that I would not want released. I have been provided a copy of Pediatric Health Center's "Notice of Privacy Practices" and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, and disclosure of my health information with Pediatric Health Center's Privacy Officer or other appropriate office personnel.

I understand that Pediatric Health Center assumes no responsibility for the use or misuse by others of my Health Information disclosed under this authorization. I release Pediatric Health Center from all legal liability that may arise from this authorization.

(PARENT OR LEGAL GUARDIAN'S SIGNATURE AND RELATIONSHIP TO PATIENT) **(DATE)**

The patient or their representative may revoke this authorization by notifying in writing Pediatric Health Center's designated privacy officer. 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. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to re-disclosure by the recipient.

(PREVIOUS PHYSICIAN)

(ADDRESS)

_____

(TELEPHONE & FAX NUMBER)