PEDIATRICS AND ADOLESCENT MEDICINE, P.A.

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755 MT. VERNON HWY., N.E.
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404-255-6335
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HIPAA Authorization for Release of Information

Patient Information

Patient Name (Last, First, MI): _____

Address: _____

Phone Number: (___)_____ Date of Birth: _____

This Authorization applies to the following information:

I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive heath information and I expressly consent to the release of the information.

☐ Growth Charts ☐ Laboratory Records ☐ Birth Records

☐ Immunization Records ☐ Progress Notes ☐ Emergency Department Visit

☐ Clinic Notes ☐ Discharge Summary ☐ Correspondence

☐ X-Rays/X-ray Reports ☐ Other: _____

Treatment Dates: from (Month/Day/Year) _____/_____/_____ to (Month/Day/Year) _____/_____/_____

The information may be released as follows (Please provide address and phone number):

From (Person/Organization providing the information): _____

Address: _____ Phone: _____

To (Person/Organization receiving the information): _____

Address: _____ Phone: _____

Purpose of the release:

☐Continuity of Treatment ☐ Other (Please specify): _____

I understand that the Information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the discloser of Information to a recipient who is not subject to the Heath Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPPA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from the P.A.M.P.A.. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's heath care and the payment for the patient's heath care will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical record copes, please ask about the copy fee by law that may apply. I represent that I have the authority and voluntarily grant permission for the information to be released as described above.

_____ _____

Patient/Parent/Legal Guardian Printed Name | Parent/Legal Guardian Signature | Date

_____ _____

Patient Signature is 14 or Older | Witness Signature for Patient/Parent/ Legal Guardian | Date