



2155 Post Oak Tritt Rd
Suite 100
Marietta, GA 30062
Phone: (770) 973-4700
Fax: (770) 565-0326

11755 Pointe Place
Suite C
Roswell, GA 30076
Phone: (770) 740-0601
Fax: (770) 346-7768

100 Stone Forest Drive
Suite 300
Woodstock, GA 30189
Phone: (770) 517-6804
Fax: (770) 517-6526

HIPAA Authorization for Release of Information

Patient Information

Patient Name (Last, First, MI): _____ **Date of Birth:** _____

Address: _____ **Phone Number:** _____

Information to Be Released

I understand the information disclosed may include sensitive health information such as psychiatric/psychological records, substance use history, HIV/AIDS status, and other confidential medical information. I voluntarily consent to the release of the following:

- ☐ Growth Charts ☐ Laboratory Records ☐ Immunization Records ☐ Progress Notes
☐ Clinic Notes ☐ Correspondence ☐ X-Ray Reports ☐ Other (please specify) _____

Treatment Dates: From: (Month/Day/Year) ____/____/____ to (Month/Day/Year) ____/____/____

Release To (Recipient of Records)

Name/Organization: _____ **Phone Number:** _____

Address: _____

Purpose of Release (check one):

- ☐ Continuity of Treatment ☐ Other (please specify): _____

Authorization Terms

I understand:

- The information released will be limited to what is necessary for the stated purpose.
- If released to a non-HIPAA-covered entity, the information may be re-disclosed and may no longer be protected by federal privacy regulations.
- This authorization is valid for **90 days** from the date of signature unless otherwise specified.
- It only applies to care received **prior to** the signature date.
- I may revoke this authorization in writing at any time by submitting a revocation form to PAMPA.
- Revocation will not affect information already released.
- My health care and payment for care will **not** be affected by refusal to sign.
- I have the right to inspect or copy the information disclosed, and I may request a copy of this authorization.
- A copy fee may apply in accordance with applicable laws.

Date: _____

Printed Name (Patient/Parent/Legal Guardian): _____

Signature: _____

Witness Signature for (Patient/Parent/Legal Guardian): _____