AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

___ Dunwoody Office: 1428 Dunwoody Village Pkwy Dunwoody GA 30338 Fax: 770-394-3055
___ Alpharetta Office: 3300 Old Milton Pkwy Ste 200 Alpharetta GA 30005 Fax: 770-667-1704

I hereby authorize Dunwoody Pediatrics to disclose protected health information regarding my child/children as follows:

PATIENT/BILLING INFORMATION (please print):

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Parent/Legal Guardian Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Please indicate the information or types of information to be disclosed, including dates if necessary:

_____

This request is for the purpose of: _____

Please disclose information to:

Recipient: _____

Address: _____

Phone: _____ **Fax:** _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorization is voluntary. I understand that if I have any questions about disclosures of my health information I may contact the privacy officer at the facility located above that is authorized to disclose this information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE:
_____DO NOT RELEASE (Indicate with a check mark).

_____ _____

Signature of Patient (18yrs) or Authorized Representative Date

If this document is signed by anyone other than the patient the appropriate corresponding paperwork must be submitted with this request