AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE (MEDICAL RECORDS RELEASE)

Dunwoody Office
1428 Dunwoody Village Parkway
Dunwoody, GA 30338
Phone: 770-394-2358
Fax: 770-394-3055

Alpharetta Office
3300 Old Milton Parkway, Ste 200
Alpharetta, GA 30005
Phone: 770-664-9299
Fax: 770-667-1704

DUNWOODY PEDIATRICS
Caring for your child and you!

I hereby authorize

To: _____

_____

_____

FAX NUMBER:_____

to disclose protected health information (medical records) regarding my child/children as follows:

PATIENT / BILLING INFORMATION (PLEASE PRINT):

Patient/Child's Name:_____ DOB:_____

Patient/Child's Name:_____ DOB:_____

Patient/Child's Name:_____ DOB:_____

Patient/Child's Name:_____ DOB:_____

Parent/Legal Guardian's Name:_____

Address:_____

City:_____State:_____Zip Code:_____Phone:_____

INITIAL HERE IF YOU WANT ENTIRE RECORD RELEASED:_____INITIALS

***IF YOU DO NOT WANT THE ENTIRE MEDICAL RECORD RELEASED*, PLEASE INDICATE THE INFORMATION OR TYPES OF INFORMATION TO BE DISCLOSED, INCLUDING DATES, IF NECESSARY:**

SPECIFIC DATES OR RANGE OF DATES TO BE RELEASED:_____

THIS REQUEST IS SPECIFICALLY FOR THE PURPOSE OF:_____

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 AN AUTHORIZATION. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS FROM THE DATE OF THIS REQUEST.

I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION MAY BE SUBJECT TO RE-DISCLOSUE 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 HERE WITH YOUR INITIALS TO NOT RELEASE: _____INITIALS

_____ _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN DATE

_____ _____
AUTHORIZED SIGNATURE ON BEHALF OF PATIENT OTHER THAN PARENT OR GUARDIAN DATE