Northside Pediatrics
The best care for your kids

6095 Barfield Road, Suite 200, Sandy Springs, GA 30328
Phone: 404-256-2688 Fax: 770-685-7114
250 Parkbrooke Place, Suite 200, Woodstock, GA 30189
Phone: 770-928-0016 Fax: 770-685-7114

Authorization To Release Medical Information

Patient Information

Patient Name	DOB	Patient Name	DOB

Your Current Information

Billing Name:		
Address:	City:	State/Zip:
Phone #:		

Where Records Should Be Sent

Name of Recipient:	
Address:	
Phone #:	Email:
Fax #:	

Information Requested

From Date: / / To Date: / /

☐Basic Records (includes problem list, growth chart, immunization record, and last well check)

☐Lab Results ☐Xray Report ☐Other Test Results _____

☐All Records (includes all protected health information contained in the designated dates set. This request will NOT authorize release of any medical information concerning sensitive information i.e. substance abuse, HIV related information, STI or pregnancy testing/treatment, and mental health)

This type of information can be separately requested below:

☐Other Information _____

Sensitive Information

By checking the box(es) below, I request and authorize Northside Pediatrics and Adolescent Medicine, PC (NSP) to release the following sensitive information. I understand the sensitive and confidential nature of this material and instruct NSP to transfer this information along with the other contents of my/my child's chart to the recipient listed above.

☐HIV, sexually transmitted diseases results and/or treatments

☐Drug or alcohol abuse testing and/or treatment

☐Testing and or treatment related to pregnancy, birth control or child birth

☐Anything that is marked confidential

Signature of patient (required if 13 years or older): _____

Format and Delivery Method

Select a format and circle a delivery method:
☐Paper – mail to address listed or pick-up (may incur a fee; see below)
☐Fax (to fax # listed)
☐Electronically ☐Email (to email listed) ☐Flash Drive (provided by NSP for a small fee) – mail or pick-up

If You Are Transferring

☐Select reason for transfer:
☐Moving: new address (effective date: _____) _____ _____
☐Insurance: new insurance _____
☐Age of patient
☐Distance too far: miles _____
☐Other (please list reason): _____ _____

We are constantly striving to find ways to serve our patients better. Please take a moment to provide us with your feedback on our services:

_____

_____

_____

Important Notices

• I understand that NSP may charge a fee as allowed by federal and state laws for paper records and requests by flash drive (see fee schedule below). If requested by email, attachments will be sent in an encrypted format with instructions on how to retrieve the information. Files placed on flash drive may not be encrypted or password protected – by choosing this method you are acknowledging and accepting these risks.
• I understand that it takes approximately 3-5 business days to complete this request after receipt and any payments for charges received.
• I understand that NSP may deny this request, in whole or in part, under limited circumstances as provided for under federal and state law if the access is reasonably likely to endanger the life or physical safety, or cause substantial harm, to the patient or another person. In the event NSP denies you access, NSP must provide you with a written denial which sets forth the basis of denial.

Fees For Certain Requests

❋ Paper charts ≤ 6 pages	no charge
❋ Pages 1-20 each page	$0.75
❋ Pages 21-100 each page	$0.65
❋ Pages 101 or more, each page	$0.50
❋ Maximum fee per family	$100.00 *(plus postage)*
❋ Cost of postage will be added to fee total	
❋ Cost of 16 GB flash drive	$2.57

By signing below, I affirm that I am the patient and/or the patient's personal representative and have the authority to authorize who may access or receive this patient's health information.

_____	_____
Print Name of Patient (or personal representative)	Relationship to Patient
_____	_____
Signature of Patient (or personal representative)	Date

For NSP Use Only

Verification of Identity

In Person	In Writing	Over Phone (3 of below)
☐Driver's License or other gov't issued picture ID	☐Verified Patient/Parent in our system	☐Billing Address
	☐Verified signature against documents already on file	☐Patient's DOB
☐If no picture ID, 3 forms of ID with name on them		☐Patient's SSN
		☐Mother's DOB
☐_____		☐Mother's SSN
☐_____		☐Father's DOB
☐_____		☐Father's SSN
		☐Insurance Group ID#