DV PEDIATRICS
"Where Kids Count"

Authorization To Release Information

Name Last	First	Middle	Maiden/Other	Date of Birth

Address	City	State	Zip	Telephone Number

I authorize and request:

_____

_____

_____

Phone _____

Fax _____

To Release To:

DV Pediatrics, LLC
2920 Marietta Hwy, #142
Canton, GA 30114
(770) 704-0057

The following information: (Check those to be used/disclosed)

- o Dates
  From _____ To _____
- o Discharge Summary
- o History and Physical
- o Operative Report
- o Pathology Reports
- o Laboratory Reports
- o Radiology Reports
- o Progress Reports
- o EKG Reports
- o ED/UC Reports
- o _____

The purpose of this disclosure is: (Check one or more of the following)

- o Continued Medical Care
- o Insurance Processing
- o Disability Determination
- o Legal
- o Other _____

I understand that a photocopy of this authorization shall be considered as valid as the original. I may inspect at no charge, and arrange for photocopies/electronic copies for a reasonable charge, of the record or information that is to be used or disclosed, by contacting a DV Pediatrics, LLC medical record department. I may receive a copy of this authorization. I further understand that this authorization shall be valid for 180 days or until the purpose of the request is fulfilled, unless otherwise stated: _____. I understand that I am under no obligation to sign this form, and that, with certain exceptions, health care providers may not condition treatment, payment, or enrollment or eligibility for health plan benefits on obtaining an authorization. Exceptions include situations where authorization was sought for research-related treatment, or if the provision of healthcare is only for the purpose of creating protected health information for disclosure to a third part, or health plan enrollment or eligibility. I understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that if I refuse to authorize release of information required to process insurance reimbursement, I may be financially responsible for services. Consequences of refusal to consent, if any, include dismissal _____. This authorization may be revoked by me at any time through written notice to DV Pediatrics, LLC, except to the extent that information has already been released in reliance upon the authorization. Revocation of this authorization will be effective following receipt of the written revocation by DV Pediatrics, LLC. Information released pursuant to this authorization could potentially be re-disclosed by the recipient and no longer protected by HIPPA or other privacy laws.

I understand that my medical record and information in connection with the organization / hospital / treatment date(s) stated above may contain reports, records or information about mental health, developmental disabilities, alcohol and/or drug abuse, acquired immune deficiency syndrome (AIDS) / HIV test results and / or information, intoxication tests, and / or fetal monitor traces.

_____ _____
Patient Signature Date Signed

_____ _____
Signature of Parent/Guardian/Personal Representative Date Signed
(State relationship to patient)

_____ _____
Witness Signature Date Signed

Rev 11/12/2013