Authorization for release of patient information

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

I hereby authorize:

Name: _____ Address: _____

Phone: ( )_____-_____ Fax: ( )____-_____

To disclose the above name individual's health information as described below:

Date(s) of service Requested (if known) or Provider:

Description of information to be released: (check all that apply)

☐ Immunization Records ☐ Radiology/Imaging reports ☐ Most recent history and physical

☐ Radiology films ☐ Laboratory reports ☐ Consultations

☐ Progress notes ☐ Entire medical record ☐ Other:_____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used the following individuals or organizations:

SUGARLOAF PEDIATRICS Phone: (678)377-1113

3525 Sugarloaf Pkwy Fax: (678)377-9390

Lawrenceville, GA 30044

Description of the purpose of the use and/or disclosure:

☐ Continuing care ☐ Second Opinion

☐ Consultation ☐ Insurance

☐ Legal Purpose ☐ Personal Use

I understand that this authorization is voluntary and I may refuse to sign this authorization, I further understand that my healthcare and the payment of my health care will not be affected if I do not sign this form. I understand I inspect or copy the information to be used or disclosed. I understand that information used of disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations

_____ _____

Signature of Patient Representative Date

_____

Printed Name of Patient or Patient Representative