PEDIATRICS AND ADOLESCENT MEDICINE, P.A. (PAMPA)

2155 POST OAK TRITT RD	11755 POINTE PLACE	100 STONE FOREST DRIVE
SUITE 100	SUITE C	SUITE 300
MARIETTA, GA 30062	ROSWELL, GA 30076	WOODSTOCK, GA 30189
PHONE: (770) 973-4700	PHONE: (770) 740-0601	PHONE: (770) 517-6804
FAX: (770) 565-0326	FAX: (770) 346-7768	FAX: (770) 517-6526

HIPAA Authorization for Release of Information

Patient Information

Patient Name (Last, First, MI): ____ Date of Birth: _______________

Address: ____

Phone Number: ______________________

This Authorization applies to the following information:

I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and or other sensitive health information and I expressly consent to the release of information.

- ☐ Growth Charts
- ☐ Laboratory Records
- ☐ Immunization Records
- ☐ Progress Notes
- ☐ Clinic Notes
- ☐ Correspondence
- ☐ X-Ray Reports
- ☐ Other (Please Specify) ____

Treatment Dates: from (Month/Day/Year) ____/____/____ to (Month/Day/Year) ____/____/____

Records Released To:

Person/Organization receiving the information: ____ Phone: ______________________

Address: ____

Records To Be Received From:

Person/Organization providing the information: ____ Phone: _____________________

Address: ____

Purpose of the release:

Continuity of Treatment Other (Please specify) ____

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This authorization only applies to treatment occurring before the dates of signature. I may decline to sign this authorization. I understand I may revoke this authorization in writing at any time by completing a form available from PAMPA. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical copies, please ask about the copy fee by law that may apply. I represent that I have authority and voluntarily grant permission for the information to be released as described above.

Date: __________Patient/Parent/Legal Guardian: (Printed Name) ________________________ (Signature)__________________

Witness Signature for Patient/Parent/Legal Guardian: ____