

GEORGIA PEDIATRIC PULMONOLOGY ASSOCIATES, P.C.
Patient Authorization to RELEASE Protected Health Information

This authorization permits Georgia Pediatric Pulmonology Associates, P.C. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.). I am aware that I do not have to sign this authorization in order to receive treatment from Georgia Pediatric Pulmonology Associate, P.C..

Medical Information on:

PRINT PATIENT'S Full Name

PATIENT'S date of birth

PRINT NAME of Parent/Legal Guardian or Patient
(if 18 years of age or older)

DAY phone number

Check (√) one, I am the: **Patient (must be 18years of age or older)** **Parent or**
 Legal Guardian with custody (please state relationship to the patient: _____)

FOR OFFICE USE ONLY:

CALL to pick up records:

OR

MAIL records to:

 DAY phone number

 PRINT Name of Individual(s) or Agency

 Date Picked Up

 PRINT (Street Address or Box Number)

FAX RECORDS TO:

 PRINT name of Agency or Individual(s)

 PRINT (City, State and Zip Code)

(____) _____

FAX Number

- I place no limitations on history or illness (including HIV, and/or AIDS, genetic, drug dependency or psychiatric information) or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders.
- I authorize the inspection of the above information by the above named agency/person and/or to the furnishing of a Photostat or other copies.
- I understand that unless otherwise limited by state or federal regulation, I may withdraw this consent at any time by submitting my withdrawal request in writing. The withdrawal of this authorization does not affect any health information prior to Georgia Pediatric Pulmonology Associates receiving a written notice of withdrawal.
- I hereby release Georgia Pediatric Pulmonology Associates, PC and its officers, directors, agents, and employees from any and all liabilities, responsibilities, damages, losses, and claims, which might arise from the release of information, authorized above.
- In furtherance of this authorization, I do hereby waive all provisions of the law and privileges related to the disclosures hereby authorized.
- I understand that the Practice may receive payment from a third party in exchange for using or disclosing the PHI.
- I hereby acknowledge that I have read (or had someone read to me) the above statements and that I fully understand the above statements and do expressly and voluntarily authorize the disclosure of this medical information to the individual, agency named above.

Any disclosure of medical information by the recipient(s) is prohibited except when implicit in the purpose of this authorization.

This authorization expires _____ (insert applicable date or event or insert "no expiration designated") or in 6 months (12months for school requests), whichever is shorter, and no further use/disclosures as described above may be made after the expiration. Authorization applies on for specified treatment dates prior to and on the date of signature, unless otherwise specified. Specified exceptions for future-dated releases are:

Signature: _____ **Date:** _____

INTERNAL OFFICE USE ONLY

Faxed Mailed Pick-up/Called: _____ Date: _____ Initials: _____