

**PEDIATRICS AND ADOLESCENT MEDICINE, P.A.**

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**HIPAA Authorization for Release of Information**

Patient Information

Patient Name (Last, First, MI): \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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 the information.

- |                      |                    |                            |
|----------------------|--------------------|----------------------------|
| Growth Charts        | Laboratory Records | Birth Records              |
| Immunization Records | Progress Notes     | Emergency Department Visit |
| Clinic Notes         | Discharge Summary  | Correspondence             |
| X-Rays/X-ray Reports | Other: _____       |                            |

Treatment Dates: from (Month/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_ to (Month/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

The information may be released as follows (Please provide address and phone number):

From (Person/Organization providing the information): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

To (Person/Organization receiving the information): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Purpose of the release:

Continuity of Treatment      Other (Please specify): \_\_\_\_\_

I understand that 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 date 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 the P.A.M.P.A.. 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 record copies, please ask about the copy fee by law that may apply. I represent that I have the authority and voluntarily grant permission for the information to be released as described above.

\_\_\_\_\_  
Patient/Parent/Legal Guardian Printed Name

\_\_\_\_\_  
Parent/Legal Guardian Signature      Date

\_\_\_\_\_  
Patient Signature if 14 or Older

\_\_\_\_\_  
Witness Signature for Patient/Parent/Legal Guardian      Date