



Authorization for the Use and / or Disclosure of Protected Health Information

I authorize the use and / or disclosure of my protected health information as described below. I understand that this authorization is voluntary. I understand that my protected health information will only be released to the person listed below. The processing fee is \$_____.

Patient Name: _____

Date of Birth _____

My authorization applies to specified records checked below:

- All records
- Records within this date range _____ to _____
- Physician notes only
- Immunization records only
- Labs / X-ray reports only
- Other _____

I authorize Kids & Teens Primary Healthcare to release my records directly to the party listed below (Please provide the Name, address, phone and fax if possible):

I would like my records _____ **mailed**, _____ **faxed**, _____ **pick up**

I understand that I have the right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/ or disclose my protected health information have acted in reliance upon this authorization. Otherwise, this authorization expires 1 year from the date signed.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Kids & Teens Primary Healthcare.

My protected health information will be disclosed for the following purposes:

- Continuation of medical care
- Other _____

Signature

Date

Name or Personal Representative

Relationship to patient

2785 Lawrenceville Hwy, Suite 207 Decatur, Georgia 30033
Phone (770)621-0245 Fax (770)621-0819