



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 office that is listed below.

Patient Name: _____ Date of Birth _____

Please provide the following information about the Providers office to release the records to us:

Office _____

Address _____

Phone _____ Fax _____

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 the following office to receive the specified protected health information by mail or by fax:

Kids & Teens Primary Healthcare
2785 Lawrenceville Hwy, Suite 207
Decatur, GA 30033
Fax: 770-621-0819

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. I have the right to inspect and receive a copy my own protected health information to be used or disclosed in accordance with regulations found under 45 C.F.R. 164.524.

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