CARTERSVILLE PEDIATRIC ASSOCIATES, PC
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Parent/Legal Guardian Name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

RECEIVING PARTY

□ Mail records to:

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

□ I will pick up my medical records in person.

□ I authorize _____to pick up my medical records in person.
(Name of person authorized to receive records)

INFORMATION AUTHORIZED FOR DISCLOSURE:

□ Complete Medical Record
□ Medical History and Physical Exam
□ Immunization Records
□ Progress Reports
□ Lab Results
□ Other: _____*(please specify)*

PURPOSE OF DISCLOSURE:

□ Personal Request
□ Transferring Records to a Different Doctor
□ Continuing Medical Care/Specialist
□ Legal Action/Review
□ Insurance Reimbursement
□ Other: _____*(please specify)*

- **Unless otherwise revoked, this authorization will expire on _____. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which it was signed.**
- **I understand** that I have the right to revoke this authorization at any time. **I understand** that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. **I understand** that the revocation will not apply to information that has already been released in response to this authorization. **I understand** that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim.
- **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules.
- **I understand** that this facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN **DATE**

_____

RELATIONSHIP *(If not patient)*

INTERNAL USE ONLY

□ Faxed □ Mailed □ Picked Up □ Called Initials _____ Date_____

□ Cartersville Pediatric Associates
P.O. Box 200429
958A Joe Frank Harris Parkway, Suites 101 &105
Cartersville, GA 30120
Ph :(770) 386-3011 Fax: (770) 386-9451

□ Cartersville Pediatric Associates at Lake Pointe
3950 Cobb Parkway, N.W.
Suite 701
Acworth, GA 30101
Ph: (770) 974-1801 Fax: (770) 974-9807