Preston Ridge Pediatric Associates, PC

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE OR TRANSFER PROTECTED HEALTH INFORMATION TO THIRD PARTIES

_____ _____
Patient's Name Date of Birth

_____
Address/Phone Number

By signing this authorization, I authorize Preston Ridge Pediatric Associates, PC to use, disclose, or transfer certain protected health information (PHI) about me or my dependent to or for the party or parties listed below.

Please check box for requested items:

☐ Medical summary (Includes: List of recurrent problems, List of known allergies, Vital signs from recent annual physical exam, Immunization list, Growth chart)

☐ Complete medical records (there is a copying fee for this service-please call for total cost)

☐ Other: (Please be specific) _____

Release or transfer to:

_____
Name

_____
Address

_____
City, State, Zip

This authorization will expire on _____/_____/_____ or one year from date of signature below.

When my information is used, disclosed, or transferred pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand that these records may include psychiatric, chemical and substance abuse, HIV and AIDS information unless specifically prohibited above. I have the right to revoke this authorization in writing except to the extent that Preston Ridge Pediatric Associates, PC has acted in reliance upon this authorization. My written revocation must be submitted to Preston Ridge Pediatric Associates, PC's Privacy Officer at *3400A Old Milton Pkwy, Suite 330, Alpharetta, GA 30005*

_____ _____
Signature of Parent/Legal Guardian/Patient (If 18+) Relationship to Patient (mother, father, self, etc.)

_____
Date Signed