

Preston Ridge Pediatric Associates, PC
3400A Old Milton Parkway, Ste 330, Alpharetta, GA 30005 770-751-6111 / Fax 770-772-6099
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

FAX: (_____) _____-

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