ABC Pediatrics

Authorization for Release/Use of and Disclosure of Protected Health Information

Name of Child_____ DOB_____

This authorization permits **ABC Pediatrics** to use and/or disclose the following individually identifiable heath information about my child. Please indicate below:

Full Medical Records – Yes / No	Medical Summary – Yes / No
Immunization Records – Yes / No	

This information will be used for the following purpose:

_____

(Ex. Transferring to Another Practice, At the Request of the Parent, Etc.)

Release information to _____

(Name, address, phone/fax number)

This authorization will expire on _____

(Expiration Date or Defined Event)

The Practice will not charge for copies of Immunizations Records or a Medical Summary. We charge $5.00 for 3231, 3300, 3189, School Medication Authorization and $10.00 for forms that require a doctor's review such as: sports, camp, college, or physical forms. We charge $30.00 for full medical records for the first request and $20.00 for each additional request not exceeding $70.00 per family. In each instance, it must be payable on the day this form is signed.

I do not have to sign this authorization in order to receive treatment form **ABC Pediatrics.** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: **ABC Pediatrics**, 735 Glynn Street South, Fayetteville, Georgia 30214. For your convenience, call us at 770-461-4126. Fax: 770-461-8852.

Signed by _____ _____

Signature of Parent/Legal Guardian — Date

_____ _____

Print Name of Parent/Legal Guardian — Relationship to Patient