FORM TO REQUEST MEDICAL RECORDS FROM ANOTHER PROVIDER.

PEDIATRIC ASSOCIATES

POLICY 3.3

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (AUTHORIZATION TO RELEASE MEDICAL RECORDS)

Patient Name:______________________________ Date of Birth:______________________________

Patient Address:____________________________ ____
City, State and Zip Code

I hereby authorize the use/disclosure of my protected health information as described below.

1. The information that may be used/disclosed is the following.
   ____All of my protected health information including privileged information (HIV/AIDS< psychological, drug/alcohol information)
   ____All of my protected health information with the exception of privileged information (as described below)
   ____Other (describe in a specific and meaningful fashion):____
   ____

2. The information will be used/disclosed for the following purposes: **Transfer records to Pediatric Associates**

3. Persons/organizations authorized to use/**disclose** the information (check one):

   Name of Practice: ____________________________________ Street Address: ____________________________

   City: ___________________________ State: _____________ Zip:_______ Telephone: ___________________________

   Fax #: __________________________

4. Persons/organizations authorized to receive the information:

   Pediatric Associates, 200 South Enota Drive, Suite 150 Gainesville, Ga. 30501

5 This authorization will expire (check one):
   ___ 90 days from the date of signing
   ___ When I revoke this authorization in writing as described below
   ___ Other expiration event that relates to you for the purpose of the use/disclosure
   ___ Other (specify date) ____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

________________________________ ____________________________
Signature of Parent/Guardian Date

________________________________ ____________________________
Print Name of Parent/Guardian Relationship to Patient

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