PEDIATRIC WORKS

6065 Lake Forrest Drive. Ste 250
Atlanta, GA 30328
Phone: 404 301 2191
Fax: 404 301 4177

Authorization to Release or Disclose Protected Health Information Patient's

Patient's Name: _____
Date of Birth: _____
Date of Request: _____
Day Time Ph: (_____)_____
Address:

_____

(Street, city, state, zip code)

Please list where Pediatric Works is to **request** medical records **from**:

Office: _____
Address:_____
(Street, city, state, zip code)
Phone Number: (_____)_____
Fax Number: (_____)_____
Dates of Service: _____

Reason for request:

Continuity of Care

The following information is to be disclosed to Pediatric Works via fax:

404 301 4177

(Please send ONLY the information listed below.)

All **Problem List** **Immunization Record** **Medication List**
Well Visit **Growth Charts** **Drug Allergy**
History ADHD History (if applicable)

I give permission for my providers to speak directly to each other regarding care coordination at 404 301 2191.

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Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand the revocation will not apply to information already released based on this authorization.

Other Rights: a) I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I do not specify an expiration date, event or condition, this authorization will expire in twelve(12) months from date signed. By signing this form, I understand and accept full responsibility for the medical records I am requesting. I relinquish Pediatric Works of any and all accountabilities concerning these medical records.

Signature of patient or legal representative: _____

If signed by legal representative, relationship to patient:_____

Date: _____