

**AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS AND
DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

Patient Name: _____

Date of Birth: _____

Patient Address: _____

SSN: _____

By signing below, I hereby authorize:

Doctor (or person that has medical records) _____

Address _____

To release or disclose information about me or my child (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below.

I am requesting the following medical information to be released or disclosed. **Initial one option only.**

_____ Date of Service or specific records to be released: _____

OR

_____ Authorization to release all medical records.

If you do NOT want certain medical information released or disclosed, please specify by date of service, test, etc.

Send the above requested records to:

Name Pediatric, Adolescent Surgical Associates, P.C.

Address 5455 Meridian Mark Road, Suite 570
Atlanta, GA 30342

Telephone 404.252.3353

Fax 404.252.0645

Expiration date or an expiration event.

Unless dated differently, authorization is valid for one (1) year. _____

This information about you or your child 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 released 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 or Legal Guardian

Date

I have authority to act for the patient because I am:

Relationship to patient