



Authorization for Request of Medical Records and Disclosure of Protected Health Information to Third Parties

Patient Number

Pediatric Adolescent Surgical Associates, P.C. 5455 Meridian Mark Road . Suite 570 Atlanta . GA 30342 404.252.3353 FAX 404.252.0645

Patient Name _____ Date of Birth _____
 First Middle Last Month Day Year
 Patient Address _____ SSN _____ - _____ - _____
 Street Apt #
 City State Zip Code

By signing below, I hereby authorize: **DOCTOR OR PERSON THAT HAS THE REQUESTED RECORDS.** To release or disclose information about me and 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.

Doctor or Person _____
Full Name

Address _____
 Street Apt #
 City State Zip Code Phone _____ - _____ - _____

I am requesting the following medical information to be released or disclosed.

- check one Authorization to release all medical records
 Authorization to release date of service or specified medical records

Date of Service _____ Specified record(s) _____
Month Day Year to be released please list

Date of Service _____ Specified record(s) _____
Month Day Year to be released please list

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

Date of Service _____ Specified record(s) _____
Month Day Year not to be released please list

Date of Service _____ Specified record(s) _____
Month Day Year not to be released please list

SEND THE ABOVE REQUESTED RECORDS TO:



Pediatric Adolescent Surgical Associates, P.C.
5455 Meridian Mark Road . Suite 570 Atlanta . GA 30342
404.252.3353 FAX 404.252.0645

Expiration date or an expiration event.

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

Parent/Guardian Signature _____ Date _____
Month Day Year
or Patient if 18 years old, older or emancipated

I have authority to act for the patient because I am: Mother of child Father of child Legal Guardian
 check one
 Step Father of child Step Mother of child Other _____
 Please list name