AUTHORIZATION TO TRANSFER / DISCLOSE HEALTH INFORMATION

Revocation
Date Revoked: ___________________

Patient Name: __________________________ Medical Record No.__________________________

Address: ____

I authorize ____ to transfer/disclose my child's health
Name of Provider, Practice or Institution
information as described below:

Previous Provider's Phone Number: _________Previous Provider's Fax Number: _____________

1. **Type of information:** The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

____ Entire medical record (all information)
____ Physician and Professional Consult Progress Notes
____ Diagnostic reports (lab, x-ray, etc.)
____ History and physical
____ Medication and treatment records
____ Immunization Records
____ Medical Summary
____ Other (Describe as specifically as possible):
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2. **Recipient of information** - The information identified above may be transferred to, or disclosed to, the following individual(s) or organization(s):

ABC Pediatrics, PC
Attn: Medical Records
735 Glynn Street South
Fayetteville, GA 30214
Phone: 770-461-4126 Fax: 770-461-8852

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

3. **Purpose of use/disclosure -** This information described on the previous page will be used for the following purpose(s):

   ____ Initiated at the request of the parent.

   ____ Transferring to local provider

   ____ Other (please describe): ____

Authorization Statements/Signatures:

4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to ABC Pediatrics, PC. I understand that the revocation will not apply to information that has already been released in response to this authorization.

6. Unless I specify differently, this authorization will **expire in one year from date or** ______________.

____ ______________________________
Signature of Patient or Parent or Legal Guardian **Date**

____
Print Name

____
Relationship to Patient