Peds Care, P.C.

1933 Shields Rd. Dalton, GA 30720
Phone: (706) 278-6628 Fax: (706) 272-3832

Authorization for Release of General Information

_______________________________________ _______________________
Parent/Guardian/Custodian Name- Please Print Relationship

_______________________ _______________________ _______________________
Street Address City/ State/ Zip Telephone

Do you have LEGAL CUSTODY of the child/children? YES NO

Patient ___________________________________ Date of Birth_______/_______/________

Patient ___________________________________ Date of Birth_______/_______/________

Patient ___________________________________ Date of Birth_______/_______/________

I hereby authorize:	**To send records to:**
______________________________ Name of Individual / Organization	______________________________ Name of Individual / Organization
______________________________ Street Address	______________________________ Street Address
_________________ Phone: _____________ City/ State/ Zip	_________________ Phone:_________ City/ State/ Zip

The following information (check all boxes that apply):

- ☐ **Immunization Record only (no charge)**
- ☐ **Last 1 yr. medical records ($ 20.00)**
- ☐ **Last 2 yrs medical records ($ 40.00, more if greater than 20 pages)**
- ☐ **Entire medical record (Price varies: quote)**
- ☐ **Other** _________________________

Reason for Medical Records:

- ☐ **Attorney**
- ☐ **Moving**
- ☐ **Change of Insurance**
- ☐ **Dissatisfaction**
- ☐ **Other**_________________________
  ____

- I understand that records released may include information about genetic conditions, psychiatric conditions, HIV/AIDS, STD, and substance abuse.
- I understand that I may revoke this authorization at any time by submitting a written revocation on a form provided by Peds Care, P.C provided that such revocation shall not be effective with aspect to any use or disclosure made by Peds Care, P.C. in reliance on this Authorization prior to the date of Peds Care ,P.C
- I understand that Peds Care, P.C. cannot require me to sign this Authorization in order to receive treatment unless the provision of healthcare by Peds Care, P.C. is solely for the purpose of creating protected health information for disclosure to a third party(e.g., an employee physical exam) or for research-related treatment, in which situations Peds Care, P.C. will not provide the service unless I sign this Authorization.
- I understand that the information used or disclosed by Peds Care, P.C. pursuant to this Authorization may be subject to redisclosure by the recipient in which case it might no longer be protected under the HIPAA Privacy Rule. However, I understand that in some cases, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I authorize Peds Care, P.C. to copy this Authorization and send the recipient the redisclosure notice required under the Federal Substance Abuse Confidentiality Requirements, whether or not my records contain information protected by those laws.
- This Authorization will expire on the following date or event ___________(or within 30 days if no other date is specified).

_______________________________ ___________________ __________
Signature of Parent/Legal Guardian/Patient(if 18 yrs. or older) Relationship Date