Authorization of Release of General Information

( ) Send my records to: **( ) Obtain records from:** **( ) Copy for Parent/Guardian- Fee may apply**

Peds Care, P.C.

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

____ _______________________
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________/________/_________

Receiving Facility, please provide a copy of the following. If additional information is needed, we will request it at a later time. Thank you.

- **Shot Record**
- **Allergy List**
- **Newborn Records if child is < 1 yr old**
- **Problem List**
- **Medication List**

- 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 (18 yrs. or older) Relationship Date

Internal Use Only: (Please list Name of Clinic you are sending records to or obtaining records from below)

____ ____
Name of Individual / Organization Street Address

__________________ _________ ________ ______________________ __________________
City State Zip Code Phone Number Fax Number

____ ______________________ ___________________
Employee Signature **Action Taken** **Date**