

PRIMECARE PEDIATRICS

15A Baynard Park, Newnan, GA 30265

Phone: (770) 251-5253; Fax: (770) 251-5254

**HIPPA COMPLIANT AUTHORIZATION
FOR THE RELEASE OF PATIENT INFORMATION****PATIENT'S NAME:** *(Last, First, Middle Initial)***DATE OF BIRTH:**

I hereby request and authorize the release and disclosure of all health information by:

[Name of Person or Facility required to release information]Address: _____
Street City State/Zip Code

Tel: (____) _____ - _____

Fax: (____) _____ - _____

The purpose of this release is *(check all applicable)*

- Continuity of Care
- Change of locality
- Moved out of state
- At the request of parent/guardian
- Other *(state reason)* _____

 TO PRIMECARE PEDIATRICS*[Check one box only]* **FROM PRIMECARE PEDIATRICS****Information Requested** *(Please mark box to indicate all items to be released)*

From Date _____ To Date _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Full Medical Records | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Health Physical Forms |
| <input type="checkbox"/> Problem List | <input type="checkbox"/> List of Medications | <input type="checkbox"/> List of Allergies |
| <input type="checkbox"/> AIDS/HIV Information | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> X-ray and Imaging Reports |
| <input type="checkbox"/> Mental Health information | <input type="checkbox"/> Genetic testing information | <input type="checkbox"/> Drug/Alcohol abuse, diagnosis, treatment |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Doctor's Notes | <input type="checkbox"/> Other <i>(specify)</i> _____ |
| <input type="checkbox"/> Chart <i>(Chart summary, immunization record, growth charts, problem list, list of medication and allergies)</i> | | |

EXPIRATION OF AUTHORIZATION:**Unless otherwise revoked in writing, this Authorization expires on** _____ *(insert applicable date or event).***If no date is specified or indicated, the Authorization will expire in 12 months from the date of signing.**

PrimeCare Pediatrics, PC will not charge for copies of Immunizations Records or a Medical Summary. We charge a minimum fee of \$5.00 for Forms 3231, 3300, 3189, or College Immunization Forms and a minimum fee of \$15.00 for forms that require a doctor's review such as, but not limited to, Sports, Camp, College, or Physical Forms. We charge a minimum fee of \$25.00 for full medical records for the first request and a minimum fee of \$15.00 for each additional requests (for the first ten pages), and \$1.00 per page after that, per child. All requests must be made by signing the proper form by an authorized party. In each instance, the applicable fee is due and payable on the day the request is made.

I understand that I do not have to sign this authorization in order to receive treatment from PrimeCare Pediatrics, PC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: PrimeCare Pediatrics, P.C., 15A Baynard Park, Newnan, GA 30265.

A photo or fax copy of this consent shall be considered as valid as the original.

X _____
Name of Parent/Legal Guardian
(Photo ID Required)X _____
SignatureX _____
Date

If unable to sign, please document reason