

# PRIMECARE PEDIATRICS

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## AUTHORIZATION FOR RELEASE/USE OF AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I HEREBY AUTHORIZE and permit **PrimeCare Pediatrics, P.C.** to use and/or disclose the following individually identifiable health information about my child.

(Specifically check or describe the information to be used or disclosed)

*Please check all that apply:*

- Full Medical Records
- Immunization Records
- Discharge Summary
- Medical Summary
- Other \_\_\_\_\_ *(Please specify)*

Release information to \_\_\_\_\_  
Name and Address

This authorization will expire on \_\_\_\_\_  
Specify Expiration Date or Defined Event)

PrimeCare Pediatrics, PC will not charge for copies of Immunizations Records or a Medical Summary. We charge a fee of \$5.00 for Forms 3231, 3300, 3189, or College Immunization Forms and \$10.00 fee for forms that require a doctor's review such as, but not limited to, Sports, Camp, College, or Physical Forms. We charge \$10.00 for full medical records for the first request and \$5.00 for each additional request not exceeding \$25.00 per child. In each instance, the applicable fee is due and payable on the day the requested form is signed.

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., 230B West College Street, Griffin, GA 30224.**

Name of Parent /Legal Guardian: \_\_\_\_\_ Relationship to Child/Children: \_\_\_\_\_

Signature of Parent /Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_