Pediatric Endocrine Specialists

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AUTHORIZATION/ CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth:_____
Patient Address: _____

Please check ONE of the following:

○ Please release all records *from* Pediatric Endocrine Specialists *to* our new Physician or other facility:
____ Physician's Office
____ Other (specify) _____
Name: _____
Address: _____
Phone: _____
Fax: _____
(must complete all fields above or we will not send any records)

○ Please send records ***to*** Pediatric Endocrine Specialists of Georgia.

Please Release:

____ Entire Medical Record
____ Records from dates _____ to _____
____ Other (specify) _____

Reason for Request:

____ Moving
____ Changing Physicians
____ School/ Daycare
____ Insurance Purposes
____ Referral
____ Requested by Court

This information about your child is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however, that any revocation will be effective only to the extent that we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign this authorization.

By signing below, I hereby authorize Pediatric Endocrine Specialists of Georgia to use or disclose information about myself (or another person for whom I have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

_____ _____
Authorized Signature of Parent/ Guardian Date