AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME_____
LAST **FIRST** **MI**

DATE OF BIRTH: ___/_____/_____ **SS#:**_____-_____-_____ **MEDICAL RECORD #**_____

_____
ADDRESS **CITY** **STATE** **ZIP**

DAY PHONE:_____ **EVENING PHONE:**_____

I authorize _____
Previous Doctor's Name

_____
ADDRESS **CITY** **STATE** **ZIP**

_____
PHONE NUMBER **FAX NUMBER**

To release my protected health information to:
Intown Pediatric & Adolescent Medicine, PC
490 Bill Kennedy Way, Suite 101 Atlanta, GA 30316
(404) 446-4726-office (404) 446-4727-fax

INFORMATION TO BE RELEASED:	**PURPOSE OF DISCLOSURE:**
☐ From & To Dates _____ ☐ History and physical exam ☐ Office notes ☐ X-ray reports ☐ Lab reports ☐ Hospital records ☐ Medication records ☐ Immunization records ☐ Other: _____	☐ Changing physicians ☐ Continuing care ☐ At patient request ☐ Second opinion ☐ Legal ☐ Insurance/Workers' Compensation ☐ School ☐ Other: _____

I understand that this authorization will expire :_____
Expiration Date or Defined Event

I understand that I may revoke this authorization at any time by notifying Intown Pediatric & Adolescent Medicine, P.C. in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.

_____ _____
Signature of Patient or Legal Guardian **Date**