



**Authorization for Release/Use of and Disclosure  
of Protected Health Information**

Name of Patient \_\_\_\_\_ DOB \_\_\_\_\_

This authorization permits **ABC Pediatrics** to use and/or disclose the following individually identifiable health information about my child. (Specifically describe the information to be used or disclosed, such as Full Medical Records, Immunization records, 3231, Medical Summary, etc.)

\_\_\_\_\_  
(Please list description here)

Release information to \_\_\_\_\_  
(Name, address, phone/fax number)

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

The Practice will not charge for copies of Immunizations Records or a Medical Summary. We charge \$5.00 for 3231, 3300, 3189, School Medication Authorization or college immunization forms and \$10.00 for forms that require a doctor's review such as: 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 family. In each instance, it must be payable on the day this form is signed.

I do not have to sign this authorization in order to receive treatment from **ABC Pediatrics**. 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: **ABC Pediatrics**, 735 South Glynn Street, Fayetteville, Georgia 30214. For your convenience, call us at 770-461-4126. Fax: 770-461-8852.

Signed by \_\_\_\_\_  
Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_

Patient

Print Name of Parent/Legal Guardian

Relationship to