

AUTHORIZATION TO TRANSFER / DISCLOSE HEALTH INFORMATION

Revocation
Date Revoked:

Patient Name: _____ DOB: _____

I authorize _____ to transfer/disclose my child's health
Name of Provider, Practice or Institution
information as described below:

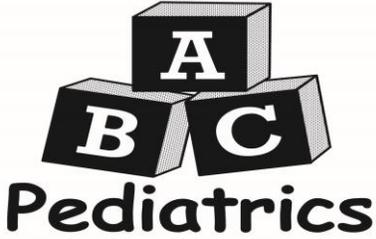
Previous Provider's Phone Number: _____ Previous Provider's Fax Number: _____

1. **Type of information:** The type of information to be used or disclosed is as follows
(check the appropriate spaces and include other information where indicated):

- Entire medical record (all information)
- Physician and Professional Consult Progress Notes
- Diagnostic reports (lab, x-ray, etc.)
- History and physical
- Medication and treatment records
- Immunization Records
- Medical Summary
- Other (Describe as specifically as possible):

2. **Recipient of information** - The information identified above may be transferred to, or disclosed to, the following individual(s) or organization(s):

ABC Pediatrics, PC
Attn: Medical Records
735 Glynn Street South
Fayetteville, GA 30214
Phone: 770-461-4126 Fax: 770-461-8852



3. **Purpose of use/disclosure** - This information described on the previous page will be used for the following purpose(s):

____ Initiated at the request of the parent.

____ Transferring to local provider

____ Other (please describe): _____

Authorization Statements/Signatures:

4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to ABC Pediatrics, PC. I understand that the revocation will not apply to information that has already been released in response to this authorization.

6. Unless I specify differently, this authorization will **expire in one year from date or** _____.

Signature of Patient or Parent or Legal Guardian

Date

Print Name

Relationship to Patient