**Atlanta Pediatric Partners, P.C.**
**3915 Cascade Rd. SW Ste. 330**
**Atlanta, GA 30331**
**(404) 699-1339 Phone**
**(404) 699-1380 Fax**

Patient Name: _____
Patient DOB: _____

Doctor/Facility: _____
Fax: _____
Telephone: _____

I hereby authorize you to use or disclose the specific information describe below, only for the purpose and parties also described below.

Description of the specific information to be used or disclosed:
_____
_____
_____

Person or entity requesting the information and authorized to make the requested use or disclosure: **Atlanta Pediatric Partners, P.C. 3915 Cascade Rd. SW Suite 310 Atlanta, GA 30331**

**Continuation of Medical Care**
This authorization shall remain in effect from the date signed below and for up to 90 days thereafter.
I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment)

_____ If this line is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Signature: _____ Relationship to Patient: _____

Date: _____