Medical Records Form

Patient Name: Patient DOB:
Doctor/Facility: Atlanta Pediatric Partners, P.C. Fax: 404-699-1380
Telephone: 404-699-1339
I hereby authorize you to use or disclose the specific information described below, only for the purpose and parties also described below.

Descriptions of the specific information to be used or disclosed:

Person or entity requesting the information and authorized to make the requested use or disclosure:
Facility: Fax:
Telephone:

Continuation of Medical Care This authorization shall remain in effect from the date signed below and for up 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 HIPAA
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing 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: