Preston Ridge Pediatric Associates, PC

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE OR TRANSFER PROTECTED HEALTH INFORMATION TO THIRD PARTIES

This is request for ☐Release ☐Transfer

By signing this authorization, I authorize Preston Ridge Pediatric Associates, PC to use, disclose, or transfer certain protected health information (PHI) about me or my dependent to or for the party or parties listed below. This authorization permits Preston Ridge Pediatric Associates, PC to use or disclose individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

_____

_____

_____

Release or transfer to:

_____
Name

_____
Address

_____
City, State, Zip

This authorization will expire one year from date below unless otherwise specified to expire on _____.{Expiration Date or Defined Event}.

When my information is used, disclosed, or transferred pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand that these records may include psychiatric, chemical and substance abuse, HIV and AIDS information unless specifically prohibited above. I have the right to revoke this authorization in writing except to the extent that Preston Ridge Pediatric Associates, PC has acted in reliance upon this authorization. My written revocation must be submitted to Preston Ridge Pediatric Associates, PC's Privacy Officer at *3400A Old Milton Pkwy, Suite 330, Alpharetta, GA 30005*

Signed by:_____
Signature of Parent/Legal Guardian **or** Patient (18 and older)

_____
Relationship to Patient

_____
Print Name of Patient(s) Date of Birth

_____
Date

_____
Print Name of Parent or Legal Guardian