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Michael G. Anderson, MD, FAAP
Stephanie H. Anderson, ND, RN, CS

CHILDREN'S PEDIATRIC CENTER: EAST MAIN

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information

Last Name:_______________________________________ First:___________________________________MI:______
Birthday:_______________________SS#:_________________________Medical Record #: ____________________
Address: ____
City:____ State:_______________ Zip____________________
Day Phone: (_________)______________________Evening Phone: (_________) _____________________

☐ I authorize Children's Pediatric Center to use or disclose my protected health information as indicated below to: (Name of entity to receive this information)

Last Name:_______________________________________ First:___________________________________MI:______
Address: ____
City:____ State:_______________ Zip____________________
Day Phone: (_________)______________________Evening Phone: (_________) _____________________

☐ I authorize: (Name of entity to release this information)

____

to release my protected health information to Children's Pediatric Center, as indicated below.

Information To Be Released	Purpose of Disclosure
☐ From & To Dates	☐ Changing physicians
☐ History and physical exam	☐ Continuing care
☐ Office notes	☐ At patient request
☐ X-ray reports	☐ Second opinion
☐ Lab reports	☐ Legal
☐ Hospital records (Op note, Discharge summary)	☐ Insurance/ Workers' Compensation
☐ Medication records	☐ School
☐ Other:	☐ Other:___________________________________

I understand that this authorization will expire: **(Expiration Date or Defined Event)** _________________________

I understand that I may revoke this authorization at any time by notifying Children's Pediatrics Center in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.

Signature of Patient of Legal Guardian:____Date: ____________
Effective Date:______________________