

# Cobb Pediatric Associates, PC

## AUTHORIZATION TO RELEASE/REQUEST HEALTH INFORMATION

I hereby authorize Cobb Pediatric Associates, PC to disclose medical information from the health record of:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Please Print  
Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Please Print  
Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Please Print  
Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Please Print

Current Address: \_\_\_\_\_  
Street/ P.O. Box City State Zip

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_

**PLEASE NOTE: Only information and / or records generated from this practice may be released.**

Please specify below information you do **NOT** want released:

\_\_\_\_\_

Authorize Information Released From:

Please Send My Records To:

**Cobb Pediatric Associates**  
**1664 Mulkey Road**  
**Austell, GA 30106**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone # 770-941-7709 Fax # 770-941-6441

Phone # \_\_\_\_\_ FAX # \_\_\_\_\_

This information is to be disclosed for the purpose of \_\_\_\_\_

**Purpose of Release:** (check all that apply)

**If you are changing physicians, please mark the reason for the transfer** (check all that apply)

\_\_\_ Location \_\_\_ MA/Nurse \_\_\_ Physician \_\_\_ Age of Children \_\_\_ Office Personnel  
\_\_\_ Office Location \_\_\_ Moving \_\_\_ Insurance \_\_\_ Appt. Availability \_\_\_ Wait Time  
\_\_\_ Other \_\_\_\_\_

I understand that the health information disclosed because of this authorization may no longer be protected by the federal privacy standards and my health information might be re disclosed without obtaining my authorization. I understand that I have the right to receive a copy of this authorization. I also may refuse to sign this authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization. I may revoke this authorization at any time, except to the extent that the person (s) and/ or organization (s) listed above may have already acted in reliance upon this authorization.

This authorization will remain in effect until the following date: \_\_\_\_\_

\_\_\_\_\_  
PRINT Patient/Guardian/ or Legal Representative

\_\_\_\_\_  
SIGNATURE Patient/Guardian/ or Legal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date