

Cobb Pediatric Associates, PC

AUTHORIZATION TO RELEASE/REQUEST HEALTH INFORMATION

Patient Name: _____ DOB: _____
Please Print

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Please Print

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Please Print

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Please Print

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

Home Phone #: (____) _____ Work Phone #: (____) _____

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

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

Authorize Information Released From:

Tel # _____ Fax# _____

Please Send My Records To:

Cobb Pediatric Associates
1664 Mulkey Road
Austell, GA 30106
Tel# 770-941-7709 Fax# 770-941-6441

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 not 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