Cobb Pediatric Associates, PC

AUTHORIZATION TO RELEASE/REQUEST HEALTH INFORMATION

I hereby authorize Cobb Pediatric Associates, PC to disclose the following 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 can be released.

Please specify any information you do **NOT** want us to release:
_____

Authorize Information Released From: **Please Send My Records To:**

_____Cobb Pediatric Associates_____ _____

_____1060 Windy Hill Rd Suite 200 _____ _____

_____Smyrna, GA 30080 _____ _____

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 as a result 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**