AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

Patient Name / DOB: _____ Patient Name / DOB: _____

Patient Name / DOB: _____ Patient Name / DOB: _____

Patient Name / DOB: _____ Patient Name / DOB: _____

Contact Information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: _____

I hereby authorize Children's Medical Group to release my health information.
1875 Century Blvd. NE Suite 150, Atlanta, GA 30345

REQUEST OR / RECIPIENT INFORMATION

Please disclose the following protected health information to:

☐ Office name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Fax: _____

☐ Email: _____

☐ Mail to Contact Address Above

Please indicate the information or types of information to be disclosed, including dates if necessary

_____

Specify Date (or date ranges) if necessary _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months or on this date listed _____.

I understand that and disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law. I understand that I need not sign this authorization to assure treatment. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE: _____ DO NOT RELEASE (INDICATE with a check mark).

FEE FOR COPIES: Federal and State law permit a fee to be charged for the copying of patient records. The facility has contracted with Noble Resources Corporation (800-490-5007) to make copies. Copies will be mailed along with an invoice. Please direct all status calls to Noble Resource Corporation.

_____ _____

Signature of Patient or Authorized Representative Date