PEDIATRIC ASSOCIATES OF SAVANNAH

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Phone: 912.355.2462
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I, _____(Guardian/Patient), understand that Pediatric Associates of Savannah, PC is authorized by me to use, release, and/or disclose the Protected Health Information (PHI) as described below. I understand the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA Privacy Rule

1. Patient's Name: _____ Date of Birth:_____
2. Patient's Name: _____ Date of Birth:_____
3. Patient's Name: _____ Date of Birth:_____
4. Patient's Name: _____ Date of Birth:_____

Release To ☐ From ☐

Pediatric Associates of Savannah, PC
4600 Waters Ave., Suite 100
Savannah, GA 31404-6273
Office: (912) 355-2462
Fax: (912) 353-1836

Release To ☐ From ☐

Name: _____

Address: _____

_____

Fax: _____

I authorize copies of the Medical Records for the following period: _____ (Month Day Year) TO _____ (Month Day Year)

I authorize the following information to be sent to the above address: (Check all that apply)

- ☑ History and Physical Examination
- ☑ Lab, X-Ray, and other reports/
- ☑ Complete Vaccination Records
- ☑ Reports from other Physicians and hospitals
- ☐ Other (Please Specify) _____
- ☐ The following information should **not** be released (Please Specify): _____

☑ I do
☐ I do not

Authorize release of information related to psychological assessments (i.e. ADHD testing, therapy), AIDS/ HIV or any other communicable diseases, psychiatric care, and/or treatment for alcohol and/or drug abuse.

Reason for transfer/disclosure: _____

If transferring for insurance reasons, please specify which insurance company: _____

I hereby authorize disclosure of the health information for the above named patient. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. This authorization will expire 10 years from today's date unless otherwise specified. I understand that I may REVOKE this authorization at any time.

Signature of Parent/Guardian OR Patient if over 18: _____ **Date:** _____