**PENTA**

Pediatric Ear, Nose & Throat of Atlanta, P.C.

Putting Your Child First

404.255.2033

# AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THIRD PARTIES

Patient Name ______________ ______________ ______________
First Middle Last

Date of Birth ______ ______ ______
Month Day Year

Patient Address ______________________________ ______
Street Apt #

SSN ______ - ______ - ______

______________________ ______ ______________
City State Zip Code

By signing below, I hereby authorize: **DOCTOR OR PERSON THAT HAS THE REQUESTED RECORDS**. To release or disclose information about me and my child (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below.

Doctor or Person ______________________________
Full Name

Address ______________________________ ______
Street Apt #

______________________ ______ ______________
City State Zip Code

Phone ______ - ______ - ______

I am requesting the following medical information to be released or disclosed.

check one
- ○ Authorization to release all medical records
- ○ Authorization to release date of service or specified medical records

Date of Service ______ ______ ______ Month Day Year — Specified record(s) to be released ______________ please list

Date of Service ______ ______ ______ Month Day Year — Specified record(s) to be released ______________ please list

If you do NOT want certain medical information released or disclosed, please specify by date of service, test, etc.

Date of Service ______ ______ ______ Month Day Year — Specified record(s) not to be released ______________ please list

Date of Service ______ ______ ______ Month Day Year — Specified record(s) not to be released ______________ please list

**SEND THE ABOVE REQUESTED RECORDS TO:**

Pediatric Ear, Nose & Throat of Atlanta-Scottish Rite
5455 Meridian Marks Road NE . Suite 130 . Atlanta, Georgia 30342
PHONE: 404.255.2033 . FAX: 404.252.1901

Expiration date or an expiration event.
Unless dated differently, authorization is valid for (1) year. ______ ______ ______
Month Day Year

This information about you or your child is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information released or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

Parent/Guardian Signature ______________________________
or Patient if 18 years old, older or emancipated

Date ______ ______ ______
Month Day Year

I have authority to act for the patient because I am: Mother of child Father of child Legal Guardian
check one
Step Father of child Step Mother of child Other ______________________________
Pease list name

Reset Form