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

PENTA
Pediatric ENT of Atlanta
Where Children Are First™

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
5461 Meridian Mark Road . 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: check one
❍ Mother of child ❍ Father of child ❍ Legal Guardian ❍ Step Father of child ❍ Step Mother of child ❍ Other _____ (Please List Name)