AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

PATIENT INFORMATION	Name (First, Middle, Last): ____ Date of Birth: ______________
SENDING ORGANIZATION (The person or facility that will be sending your information)	Name of person or facility: ____ Address: ____________________________________ City: _____________ State: ___ Zip: ________ Phone: ________________
RECEIVING ORGANIZATION	Pediatric Ear, Nose, and Throat of Atlanta 5461 Meridian Mark Rd., Suite 130 Atlanta, GA 30342 Phone: 404-255-2033 Fax: 404-252-1901
REQUESTED INFORMATION	Indicate Applicable Dates of Service: ___________________ ***Check the types of information to be released:*** ☐ Any and All Records ☐ Routine Record Set ☐ Clinic Record ☐ Hospital Records ☐ Surgery Record ☐ Lab Reports ☐ Radiology ☐ Other: _____________
RELEASE INSTRUCTIONS	***Please choose release method/format:*** ☐ Paper ☐ Verbal (Recipient name: _______________) ☐ eDelivery: e-mail address: ________________________ ***Delivery Method:*** ☐ Mail (to address listed above) ☐ Fax (to number listed above)
PURPOSE OF RELEASE	☐ Continuing Care ☐ Insurance Reimbursement ☐ Legal Action/Review ☐ Other: __________

I acknowledge and agree that I have read (or had someone read to me) the following statements:

- This Authorization **expires in 12 months** from the signed date unless an alternative date is inserted here: ___________
- I place no limitations on history or illness (including HIV and/or AIDS, genetic, drug dependency or psychiatric information) or diagnosed and therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders.
- I may refuse to sign this authorization and that it is strictly voluntary and that my treatment, payment, enrollment or eligibility for benefits may not be conditions on signing this authorization.
- I may revoke my consent at any time by submitting my revocation request in writing. The revocation of this request will not affect any health information disclosed prior to Pediatric ENT of Atlanta receiving my written notice.
- I understand that information disclosed may be subject to redisclosure and may no longer be protected by federal privacy regulations.
- I understand that if I have consented to verbal release, confidential information disclosed may include information about the patient's treatment at PENTA obtained from interviews of the family, providers and hospital personnel, or from the patient's medical records, including images of any kind, and I place no limitation on the PHI disclosed pursuant to this authorization. I hereby waive the right to or interest in the confidentiality of this patient information.
- I understand that I have a right to see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask.
- I understand that I may have a copy of this signed form, if I ask for one.

ATTENTION: Please review the information below carefully. If information is missing, the request may not be processed.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and lacks capacity to sign,** a legally authorized person may sign and date the form. Please indicate your legal authority and include documentation of your relationship:

  ☐ **Legal Guardian or Conservator** ☐ **Health Care agent (Health Care Power of Attorney)**
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:

  ☐ **Parent** ☐ **Legal Guardian**

By signing, I understand that I am authorizing Pediatric ENT of Atlanta to release/obtain information as described above. I hereby release Pediatric ENT of Atlanta (and its affiliates, officers, directors, trustees, employees, medical staff members and agents) from any and all claims, liability, suits, or costs related to the use of images or disclosure of the information and materials described herein.

______________________________ Patient/Legal Guardian Signature

____________ Date

__________________________________ Authority to act on behalf of patient (attach document)

PENTA
Pediatric ENT of Atlanta
Where Children Are First

PATIENT INFORMATION: Insert the full name specific to the patient for whom information is being requested.

SENDING ORGANIZATION: Identify the full name of the person/business, address, and phone number of the entity sending the information.

INFORMATION TO BE RELEASED: This section gives us the instructions on what information is to be released. If you select "Routine Record Set," we will disclose the documents that are specific to the patient care visit. This is typically what medical offices, hospitals, or other healthcare providers need to provide information related to your care. If you select "Any and All Records," your entire record will be provided for a specific visit date or all dates. It is very helpful if you identify the date or range of dates needed by the requester.

RELEASE INSTRUCTIONS: This tells us how you would like your information delivered. We can print and mail the documents, email or eDeliver the documents securely. If you wish to view information prior to selection of documents, please identify this on the authorization form and we will contact you to set up a viewing appointment. It is Pediatric ENT of Atlanta's policy NOT to fax patient information except for direct patient care requirements (e.g. to a provider or clinic). *Please note:* If you select "verbal" release, you are permitting Pediatric ENT of Atlanta to discuss and disclose confidential Protected Healthy Information (PHI) with the named recipient. Only clinical staff is permitted to verbally release PHI.

PURPOSE OF THE REQUEST: Identify the reason why a copy of the patient record is needed. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

DURATION OF CONSENT, REVOCATION, AND OTHER INFORMATION YOU NEED TO KNOW: This consent will automatically expire in 12 months UNLESS you write some other expiration date/ the authorization is revoked at your written direction to our organization.