Authorization for Use and/or Disclosure of Protected Health Information

This form authorizes Ringgold Pediatric Clinic to use and/or disclose protected health information in the manner described below and is voluntary. Ringgold Pediatric Clinic will not condition treatment, payment, enrollment or eligibility for benefits on the execution of the Authorization. The information used or disclosed as a result of the Authorization may be subject to re disclosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations.

Please note that each section of the form must be completed in its entirety.

Patient Information

Patient Name: _____ Gender: _____Male _____Female

Date of Birth: _____ Phone: ( ) _____

Parent/Guardian/Requestor Completing Form: _____

Release To

Name: _____

Street Address: _____

City/State : _____ Zip: _____

Phone: _____ Fax: _____

Purpose

Records are to be released for the following purpose(s): (Select all that apply)

_____Medical Care _____Attorney/Legal _____Personal _____ Insurance _____Disability/SSI _____Other: _____

Information to Release

Date of Treatment/Particular Illness/Admission Requested: _____

_____ Discharge Summary _____Emergency Department Record _____X-Ray reports, labs or other tests

_____ History & Physical _____ Immunizations _____ Consultation Reports, Specify MD: _____

_____ Operative Reports _____ Registration Sheets _____Outpatient Clinic Notes, Specify Clinic (s): _____

_____ Other: _____

Patient/Parent/Legal Guardian Authorization

Unless otherwise revoked, this Authorization will expire one (1) year from the date it is signed or, if specified, on the following date, event or condition (complete if desired): _____. This Authorization may be revoked at any time. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the address below.

I, the undersigned, hereby authorize Ringgold Pediatric clinic to use and/or disclose information for my (or give relationship) _____medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

Signature of _____Patient _____Parent _____Legal Guardian _____ Date: _____

Submit

Please verify that all sections are completed in full. Upon completion, please mail or fax records to:

Ringgold Pediatric Clinic

7494 Battlefield Pkwy

Ringgold, GA 30736

706-935-5437 Fax: 706-935-3004