AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Practice:_____ **Phone:**_____
Fax:_____

Patient name:	**Date of Birth:**	**Phone:**
Address:		

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by the above-named practice.

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s):

_____

☐ Other: _____

You may disclose this health information to:

La Clinica Del Niño, P.C., dba:
Clinica Internacional de Pediatria
International Pediatric Clinics
Phone: 770.263.9101 Fax: 770.263.9102

Reason(s) for this authorization (check all that apply):

☐ At my request	☐ Other (specify) _____

This authorization ends: ☐ on (date) _____

☐ when the following event occurs_____

II. My Rights

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **OR**
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office. **OR**
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)