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, PC
3780 Holcomb Bridge Rd, Suite C
Norcross, GA 30092
Tel. 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.)