



Khizer Ahmad, MD  
Ken Chen, MD  
Tanya Bigby, MD  
Angie McGowan, PA  
Loredana Pop, NP

2213 Exchange Place SE  
Conyers, GA 30013  
(P) 770-483-4431  
(F) 770-760-7200  
www.pediatriccenter.com

## AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Telephone \_\_\_\_\_

I authorize the release of medical information as indicated below:

From: (Practice Name/Address) \_\_\_\_\_ To: (Name/Address) \_\_\_\_\_

- I would like to pick up my records: please call me at \_\_\_\_\_  
 I would like to records mailed (please indicate address above)

### What to Release: Please choose the records you would like released:

- |  |  |
|--|--|
| <input type="checkbox"/> Outpatient notes    | <input type="checkbox"/> Laboratory reports  |
| <input type="checkbox"/> X-Ray report(s)     | <input type="checkbox"/> X-ray Film(s)       |
| <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> Immunization record |
| <input type="checkbox"/> Other Specify _____ | <input type="checkbox"/> All medical records |
|  | <input type="checkbox"/> Billing records     |

**NOTE: The records listed below have special protection by laws. I authorize the release of information pertaining to:**

- |  |                              |                                |
|--|------------------------------|--------------------------------|
| The diagnosis or treatment of AIDS, including results of HIV tests           | <input type="checkbox"/> Yes | <input type="checkbox"/> No/NA |
| The diagnosis or treatment of drug and/or alcohol abuse                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No/NA |
| The treatment and/or consultation for mental health or psychiatric disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No/NA |
| Psychotherapy notes  | <input type="checkbox"/> Yes | <input type="checkbox"/> No/NA |

### Purpose of the release: Please indicate the reason for this release

- |   |   |
|---|---|
| <input type="checkbox"/> For another doctor             | <input type="checkbox"/> To obtain disability     |
| <input type="checkbox"/> Use in a lawsuit               | <input type="checkbox"/> Worker's care            |
| <input type="checkbox"/> Follow-up related to an injury | <input type="checkbox"/> Armed forces requirement |
| <input type="checkbox"/> Personal use                   | <input type="checkbox"/> Other _____              |

### Format of the release:

- Hardcopy format  Email: \_\_\_\_\_  
 Portable media device

I understand that electronic media, and delivery methods such as unencrypted email, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of [Practice Name]. I agree to assume such risks personally, and to hold [Practice Name] harmless in the event my



Khizer Ahmad, MD  
 Ken Chen, MD  
 Tanya Bigby, MD  
 Angie McGowan, PA  
 Loredana Pop, NP

2213 Exchange Place SE  
 Conyers, GA 30013  
 (P) 770-483-4431  
 (F) 770-760-7200  
 www.pediatriccenter.com

Protected Health Information is breached or compromised as a result of my directing and authorizing \_\_\_\_\_] to transmit or deliver such information electronically.

**Expiration date: This authorization will expire in sixty days unless otherwise indicated below:**

Please change the expiration date to last for \_\_\_\_\_ days.

I understand this Authorization can be revoked at any time according to the [practice name's] privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by [Practice name] and may potentially be re-disclosed by the party who received these records. [Practice name], its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.

I understand that I have the right to:

- Inspect or copy the Protected Health Information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Have an electronic copy of my medical records, or a portion thereof, transmitted to any third party or person I designate.
- Refuse to sign this Authorization.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

Signature of Patient	Date

Signature of Legal Representative	Date

+++++  
 FOR OFFICE USE ONLY

<b>Received by:</b>			
<b>Date Received:</b>		<b>Time Received:</b>	
<b>Action(s) Taken:</b>			
<b>PHI Disclosed To:</b>			
<b>Disclosure Media:</b>	<input type="checkbox"/> Hardcopy <input type="checkbox"/> Memory Stick <input type="checkbox"/> CD-ROM <input type="checkbox"/> Email <input type="checkbox"/> Other (describe)		
<b>Discloser's Signature:</b>			