Intown
PEDIATRIC & ADOLESCENT MEDICINE, P.C.

## AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

| **PATIENT NAME (*Last, First, MI*)** | | | **Date of Birth** |
|---|---|---|---|
| Address | City | State | Zip |
| Best Contact Phone | Email Address | | |
| PARENT/GUARDIAN NAME | | Relationship to Patient | |
| My signature below affirms that I am the legal guardian of the above listed patient, having full authority to request, receive and transfer Medical Health Records. I agree to take full responsibility for such records and all financial obligations. | | | |

**I hereby Authorize Intown Pediatric & Adolescent Medicine, PC to:**

☐ **Release my child's protected health information TO or FROM:** *(Please CIRCLE one & Complete Information)*

_____ Name

_____ Address

_____ City, State Zip Code

_____ Fax Number

_____ Phone Number

EMAIL: _____

***(Any documents over 30 pages cannot be sent nor received by fax and will be emailed or mailed in CD format)***

☐ **I Request my child's protected health information FROM my former pediatrician to be sent to:**

Intown Pediatric & Adolescent Medicine, P.C.
490 Bill Kennedy Way, SE Atlanta, GA 30316
PHONE (404) 446-4726 FAX (404) 446-4727
EMAIL: forms@intownpediatrics.com

**INFORMATION TO BE RELEASED:**

| | | |
|---|---|---|
| ☐ FULL Medical Record | ☐ Records From & To Dates _____ | ☐ Last Visit/Growth Chart/Immunizations |

This authorization expires 90 days (ninety) from: _____ **(Expiration Date)**

☐ ***By checking this box, I authorize records to be sent via unencrypted email to my email address on file. I accept the risks of sending and receiving Protected Health Information (PHI) via unencrypted email and I hold harmless Intown Pediatrics from any and all liability.***

**I understand that I may revoke this authorization at any time by notifying Intown Pediatric & Adolescent Medicine, P.C. in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.**

_____ **Signature of Parent or Legal Guardian**

_____ **Date**

***Any medical record not submitted directly to another medical office is subject to a $30 per record fee. Any records over 30 pages cannot be faxed. Medical Records for Attorney offices are a minimum of $50 per patient record. Guarantor accepts full financial responsibility for all patient balances at the time of medical record request. Release of medical records to another primary care facility terminates patient care with Intown Pediatric & Adolescent Medicine.***