AUTHORIZATON FOR RELEASE OF INFORMATION

I authorize:

Office/Doctor's Name: ____

Address: ____

City: ________________________ State: _______ Zip Code:______________

Phone #: ________________________ Fax #: __________________________

Email: ____

to transfer my child's/children's protected health information (PHI) to:

Green Hills Pediatric Associates
Attn: Medical Records
4322 Harding Pike, Suite229
Nashville, TN 37205

The information to be included for use and/or disclosure:

(Check one)

______ Medical Record

______ Portions of the medical record as listed below
(specify date of service, type of service etc.)

____

The information will be used or disclosed for the following purpose:

(Check one)

______ Transfer medical record to another physician
______ At the request of the individual (if no purpose is stated)
______ Other (please specify) ____

This authorization will expire on ____________________________.
(Expiration date or Defined Event)
Ex. Upon completion of request.

____ will ___ will not ____
(physician releasing records)

receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from ____________________________________. In fact, I
(physician releasing records)
have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer.

_________________________________ Patient's Name	____________________________ Date of Birth
_________________________________ Signature of Parent/Legal Guardian/ Patient (if 18 or older)	____________________________ Relationship to Patient
_________________________________ Print name of Parent/Legal Guardian/ Patient (if 18 or older)	____________________________ Date

PARENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION