AUTHORIZATION OF RELEASE OF PROTECTED HEALTH INFORMATION

I_____ hereby authorize the following healthcare providers:
(*Print: Name of parent or legal guardian)*

Name of Practice/Facility	Office address	Office phone number

to release the following information contained in the patient record of:

	Patient's Name	Date of Birth
1		
2		
3		
4		
5		
6		

Grayson Pediatrics, LLC
297 Cooper Road
Loganville, GA 30052
Phone: 678-381-2630
Fax: 678-381-2627

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that the Health Care Provider who I am asking to disclose the information to, Grayson Pediatrics, LLC, may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to further disclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that. I may revoke this authorization at any time by giving written notice to the disclosing Health Care Provider of my desire to do so.

I also understand that I cannot revoke this authorization after the disclosing Health Care Provider has already relied on it to use or disclose the protected health information. Written revocation must be sent to the disclosing Health Care Provider's office.

_____ _____
Signature of Consenting Individual, Parent or Guardian Date