AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

( ) Send my records to: ( ) Obtain records from: ( ) Copy for Parent/Guardian

PEDIATRICS OF DALTON
1409 CHATTANOOGA AVENUE
DALTON, GA 30720
706-278-5373

Fax: (706) 278-5085

I, _____, the parent /legal guardian of

_____, hereby authorize the release of the following

information from the records of _____

DOB _____ SSN_____

for the purpose of _____

covering the period of treatment from _____ to _____.

Information to be released:

( ) Doctor's notes ( ) Complete Records ( ) History & Physical
( ) Lab/ X-ray Reports ( ) Immunization Records ( ) Inpatient Records
( ) Other _____ ( ) Outpatient Records

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug related conditions; alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV related conditions. (Please initial below)

Substance Abuse ___ Psychological/Psychiatric Conditions ___ AIDS/HIV/Other STD___

I understand that I may revoke this authorization at any time by notifying POD in writing by sending a letter to the above address. I understand that if I revoke this authorization, it will not affect any actions that POD took before it received my revocation letter.

_____ _____
Signature of Parent / Guardian Date

This authorization will expire _____ (no longer than 90 days)