AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Vibrant Kids Pediatrics
10 Market Square Way, Ste 100, Newnan, Georgia 30265
(678) 423-5560
We do not accept medical records via fax; please mail to the above address.

Patient Name: (First) _____ (Last) _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

1. I authorize representatives of Vibrant Kids Pediatrics to [**release** / **request**] my Protected Health Information [**to** / **from**] the following [**facility** / **person**]:

   Name: _____

   Address: _____

   City: _____ State: _____ Zip Code: _____

   Phone: _____ Fax: _____

2. **DESCRIPTION OF PROTECTED HEALTH INFORMATION TO BE DISCLOSED**
   ❑ Complete medical record
   ❑ Partial medical record, check all that apply:
   ❑ History and Physical ❑ Consultations ❑ Discharge Summary ❑ Lab Results

3. **PURPOSE OF DISCLOSURE**
   ❑ At my request ❑ Other: _____

4. **EXPIRATION OF AUTHORIZATION**
   Unless I request in writing otherwise, I understand that this Authorization will expire on ___ / ___ / _____. If I do not specify an expiration date, this Authorization will expire ninety (90) days from the date on which I signed this Authorization.

5. **RIGHT TO REVOKE AUTHORIZATION**
   I understand that I have the right to revoke this Authorization. I must do so in writing and present the written revocation to Medical Records at Vibrant Kids Pediatrics. I understand that the revocation will not apply to any Protected Health Information that has been released in response to this Authorization.

6. **RE-DISCLOSURE**
   I understand that if my Protected Health Information is disclosed to a party other than a health care provider, health plan or health care clearing house subject to the federal privacy regulations, my Protected Health Information disclosed pursuant to this Authorization may no longer be protected by the federal privacy regulations.

7. **FEES**
   I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of any such fees.

8. **RELEASE & WAIVER**

If the Protected Health Information that I have requested Vibrant Kids Pediatrics to disclose contains any privileged psychiatric or psychological information related to the treatment of physical or mental illness, chemical dependency or alcohol abuse, or the testing or treatment of any communicable or infectious disease such as Acquired Immunodeficiency Syndrome (AIDS), Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Vibrant Kids Pediatrics and their officers, trustees, agents and employees from any and all liabilities, damages, and claims, which might arise from the release of the Protected Health Information authorized by me above.

_____ _____

Signature of Patient (or Patient's Legal Guardian) *Date*

_____

Relationship to Patient

Vibrant Kids Pediatrics LLC • 10 Market Square Way, Ste 100, Newnan, GA 30265
(678) 423-5560 • (678) 423-5563 (fax) • https://www.vibrantkids.us

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