AUTHORIZATON FOR RELEASE OF INFORMATION

I authorize:

_____

_____

_____

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