Covenant Pediatrics

Authorization for Use and Disclosure of Protected Health Information

4106 Columbia Rd, Ste 103, Martinez, GA 30907 – (706) 863-1440
3121 Peach Orchard Rd, Ste 102, Augusta, GA 30906 – (706) 792-5040

Patient Identification

Printed Name: _____ Date of Birth _____

Address:_____ Telephone_____

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City: _____State: _____Zip: _____

Information to be Released

From: _____

_____

City State Zip

_____

Phone Fax

Method of Release (circle one): Pick Up Mail

To: _____

_____

City State Zip

_____

Phone Fax

Purpose of Request

☐ Change of Primary Care Provider (PCP)

☐ Other (Specify**)**

Please check the type(s) of information to be released

☐ All records

☐ Other (specify):

If I choose to prohibit the release of HIV/AIDS or psychiatric disorders/mental health related information, I will do so with my signature, today's date (check the appropriate information to prohibit and sign as appropriate):

☐ Do not release HIV/AIDS Medical Records: Signature: _____Date: _____

☐ Do not release Psychiatric/Mental Health Records: Signature: _____Date: _____

I understand that my **express consent** is required to release any health information relating to testing, diagnosis, and/or treatment of alcohol or drug related medical problems, and this special consent will also apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health, **unless I prohibit specific action with my signature above**. I authorize the release of such confidential information to the indicated "To" party, unless prohibited by my specific instructions above. Federal regulations (42 C.F.R. Part 2) prohibits "To" party from making further disclosure of without my specific written consent or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

Notice of Time Limit and Right to Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting **a notice in writing** to the facility Compliance Officer at Covenant Pediatrics at either office address located above. This authorization will expire 60 days from today's date.

Notice of Re-Disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by Covenant Pediatrics according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our facilities, its employees, officers and physicians are hereby released from any legal responsibility or liability for further disclosure of the above information to the extent indicated and authorized herein. I understand, if I authorize Covenant Pediatrics to release my records by email, that many email servers are not a secure means of communication, nor are they obligated to abide by HIPAA regulations that protect my health information. I hold Covenant Pediatrics harmless for any undesired results stemming from my request to receive my medical records by email or by any other unsecure means.

I authorize Covenant Pediatrics to use and disclose the protected health information as described above.

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Signature of Patient, Parent, or Legal Guardian **Witness** **Date**