

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name(s):	Date of Birth:
Patient Address:	
Patient Phone:	

I authorize my previous provider :
Who is/was located at Address :
Who's Phone is :
Who's Fax is :
To disclose my protected health information for use in medical care, medical records, and/or financial records as indicated below:

This information is to be disclosed to : **Kennesaw Pediatrics PC**
 Dr. Mark A. Long
 3745 Cherokee Street, Suite 401
 Kennesaw, GA 30144
 770-429-1005
 770-429-8005 fax

Description of information to be disclosed: ***ONLY* Immunization records / Growth Charts / Problem List (completed)**

Reason for Requested use or disclosure: **To transfer or facilitate the medical care of the listed patient**

PLEASE READ AND SIGN: I understand the following:

1. I may revoke the authorization at any time by providing written notice to the practice
2. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization, or if the authorization was obtained as a condition of obtaining insurance coverage.
3. The practice will not condition treatment or payment based on my signing this authorization.
4. I am signing this authorization freely; no one has pressured or coerced me to sign this authorization.
5. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.
6. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
7. I understand that I am entitled to a copy of this authorization, at the time of its execution. If so, I will make my request known.

Patient's SIGN: (or Patient representative):	DATE:
Relationship to Patient:	Event or Date of expiration (if any):