SUNSHINE PEDIATRICS
1160 Capital Avenue; Ste. 105,
Market Center
Watkinsville, Georgia 30677
Telephone (706) 769-9410
Fax (706) 769-9475

Authorization for Use and/or Release of Information

Name of Patient _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

SUNSHINE PEDIATRICS is authorized to:

☐ Use protected health information for treatment, payment and operations.

☐ Disclose protected health information to the entity named below.

The use or disclosure of this information will result in direct or indirect remuneration to the practice named above from a third party. ☐ Yes ☐ No

☐ Name & Address of Medical Offices to **Receive** Information:

☐ Name & Address of Medical Offices to **Release** Information:

_____

_____

_____

DESCRIPTION OF INFORMATION TO BE RELEASED:

Date of Service _____ Service Provided _____

Describe in detail the level of information to be released _____

_____

PERMITTED USE OF THE DESCRIBED INFORMATION:

This authorization shall be in force and effect until: Date of Expiration _____ (or) Description of an event that will cause this authorization to expire. The event may relate to the patient or the intended use or disclosure. _____

_____

(Please Complete the Other Side)

Rights of the Patients Legal Guardian/s

I understand that I have the right to revoke this authorization at any time by sending a written notification to: **SUNSHINE PEDIATRICS.**

I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification to:

I understand that the patient treatment will not be conditioned on signing this authorization.

I understand that I have the right to refuse to sign this authorization.

Upon requesting and signing this release for medical records to leave **Sunshine Pediatrics** and change to another provider of my choice, I understand that **Sunshine Pediatrics,** has no obligation to accept the patient back into care and by the parent's permission the providers and staff of **Sunshine Pediatrics** have no obligation to give medical care from this day forward.

Signature of Patient Legal Guardian/s **Date**

Print or Type Name of Patient Legal Guardian/s

Description of Authority (attach necessary documentation)