



Authorization to Release Protected Health Information

I understand that if the person(s) and or organization(s) listed below are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standard, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards, and my health information may be re-disclosed without obtaining my authorization.

This authorization will automatically expire one year from date of signature or until _____, 20___. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on the actions they took before they received the revocation.

Patient Information:

Name	Date of Birth	Medical Record Number	
Previous Name			
Street Address	City	State	Zip Code
Daytime Phone Number			

Release Information From:

Name
Street Address/PO Box
City, State, Zip Code
Phone Number

Send Information To: Upcoming appt.date: _____
Sunrise Pediatric Neurology
 Name
3417 Canton Rd Bldg 1
 Street Address/PO Box
Marietta, GA 30066
 City, State, Zip Code
678-606-5700 **770-538-1684**
 Phone Number Fax Number

Medical Information to be released:

Office notes
 Lab results
 Radiology Reports
 EEG reports
 Other-Specify _____

For date(s) of treatment or condition _____

If you do not wish such information to be released, state information to be excluded: _____

I am requesting this information to be released for the following purpose:

Medical Treatment
 Disability
 Transfer of Care
 Insurance
 Moving
 Other
 At My Request
 Legal

A copy of this signed form will be provided to the patient.

Signature of Patient or Legal Representative	Date
Relationship, if not parent _____	

Legal documentation is required supporting his/her authority to act on a patient's behalf.

Photo Identification will be requested for all hand carry release of information requests. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.

For Clinic use

Processed by _____
 Date Completed _____