VAN METER PEDIATRIC ENDOCRINOLOGY, P.C.

1800 Howell Mill Road NW, Suite 475 Atlanta, Georgia 30318
Telephone: 678-961-2100 Fax: 678-961-2107

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Note: Form MUST be completed before signature is obtained)

PATIENT NAME _____
LAST FIRST MI

DATE OF BIRTH: / / Pt Account #: -

ADDRESS CITY STATE ZIP

DAY PHONE: _____ EVENING PHONE: _____

☐ **I authorize *Van Meter Pediatric Endocrinology, P.C.* to use or disclose my protected health information as indicated below to:**

Name of entity to receive this information

ADDRESS CITY STATE ZIP

PHONE NUMBER FAX NUMBER

☐ **I authorize** _____
Name of entity to release this information

To release my protected health information to Van Meter Pediatric Endocrinology, P.C., as indicated below.

INFORMATION TO BE RELEASED:	**PURPOSE OF DISCLOSURE:**
☐ From & To Dates _____	☐ Changing physicians
☐ History and physical exam	☐ Continuing care
☐ Office notes	☐ At patient request
☐ X-Ray reports	☐ Second opinion
☐ Lab reports	☐ Legal
☐ Hospital records (Op note, Discharge summary)	☐ Insurane/Worker's Compensation
☐ Medication records	☐ School
☐ Other: _____	☐ Other: _____

I understand that this authorization will expire: _____
Expiration Date or Defined Event

I understand that my health care and the payments for my health care will not be affected if I do not sign this frm and that I may refuse to sign it. Initials: _____

I understand that I may revoke this authorization at any time by notiying Van Meter Pediatric Endocrinology, P.C. in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization. Initials: _____

I understand that I may see and obtain a copy of the information described on this form, if I ask for it, and that I get a copy of this form after I sign it. Initials: _____

_____ _____
Signature of Patient/Parent or Legal Guardian **Date**

Effective Date: January 1, 2012