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: ___/___/___ PHONE#: ___-___

_____
ADDRESS CITY STATE ZIP

☐ **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

☐ **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.

_____
ADDRESS CITY STATE ZIP

_____
PHONE NUMBER FAX NUMBER

INFORMATION TO BE RELEASED:

- ☐ From & To Dates _____
- ☐ History and physical exam
- ☐ Office notes
- ☐ X-Ray reports
- ☐ Lab reports
- ☐ Hospital records (Op note, Discharge summary)
- ☐ Medication records
- ☐ Other: _____

PURPOSE OF DISCLOSURE:

- ☐ Changing physicians
- ☐ Continuing care
- ☒ At patient request
- ☐ Second opinion
- ☐ Legal
- ☐ Insurane/Worker's Compensation
- ☐ School
- ☐ 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 form 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