JONESBORO PEDIATRICS

ROMEO MORILES, MD, FAAP
SUPRIYA HATTANGADI KASI, MD, FAAP
TAISHA OKAFOR, MD, FAAP
SHARON BRYAN-GRANT, DNP, CPNP

AUTHORIZATION TO TRANSFER / DISCLOSE HEALTH INFORMATION

Revocation
Date Revoked: _________________
Initials of Privacy Official________

Patient Name: ________________________________ DOB:__________ Chart No._________

Address: ____

I authorize _______________________________________ to transfer/disclose health
Name of Provider, Practice or Institution

information as described below:

Previous Provider's Phone Number: ____________ Previous Provider's Fax Number: _______________

1. **Type of information:** The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

____ Entire medical record (all information)
____ Physician and Professional Consult Progress Notes
____ Diagnostic reports (lab, ultrasounds, x-rays, etc.)
____ History and physical
____ Medication and treatment records
____ Medical Summary
____ Other (Describe as specifically as possible):
____
____
____

I am aware that some of the information in the Medical Records may be of sensitive nature.

2. **Recipient of information** - The information identified above may be transferred to, or disclosed to, the following individual(s) or organization(s):

Jonesboro Pediatrics
236 Arrowhead Blvd
Jonesboro, GA 30236
Phone: 770-478-9240 Fax: 770-478-0318

Jonesboro Pediatrics
210 W Campground Rd
McDonough, GA 30253
Phone: 678-916-4010 Fax: 678-916-4014

3. **Purpose of use/disclosure -** This information described on the previous page will be used for the following purpose(s):

____ Initiated at the request of the Parent.

____ Transferring to local provider

____ Other (please describe): ____

Authorization Statements/Signatures:

4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Jonesboro Pediatrics. I understand that the revocation will not apply to information that has already been released in response to this authorization.

6. Unless I specify differently, this authorization will **expire in one year from date or ______________**.

____ ____________________________

Signature of Parent/Legal Guardian **Date**

____

Print Name

____

Relationship to Patient