

Atlanta Children's ENT, P.C.
3400-C Old Milton Parkway, Suite 465
Alpharetta, Georgia 30005
(770) 777-1100 Fax (770) 751-9089

**HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE AND USE OF
PATIENT INFORMATION PURSUANT TO 45 CFR 164.508**

Patient Name: _____ Gender: M / F

Date of Birth: _____

I Request and Authorize: _____ to release
(Please enter Primary Care Doctor's Name)

Healthcare information of the patient named above to: **Atlanta Children's ENT**

Please fax records to (770) 751-9089.

This request and authorization applies to:

Problem List for current medical condition

Other: _____

Reason for this authorization: My request Other _____

My Rights: I understand I may revoke this consent at any time except to the extent that action has already been taken on it. The information released in response to this authorization may be re-disclosed to other parties and privacy laws may no longer protect it. I understand I do not have to sign this authorization in order to receive treatment. This authorization may be revoked in writing at any time.

Signature of Parent or Legal Guardian

Date

Printed Name of Parent or Legal Guardian

Relationship to patient (Parent/Guardian)

For office use only: (Stamp when faxed)

This authorization expires one (1) year from the date signed.