MEDICAL RECORDS (PHI) RELEASE FORM

Current patients can quickly request a free, electronic copy of their Treatment/Record Summary via the Patient Portal. Log in to your account at www.cobbpeds.com.

For all paper record copy requests, requests for records to be sent to a third-party, or for inactive patients without a portal account: this form must be completed in its entirety or your request may be delayed.

Patient Name:______________________________ **D.O.B.** ____________ **Age:** ______

Billing Address: ____

City: ____________________ **State:** ______ **Zip:** ________ **Telephone:** ______________

(***If patient is a minor***) **Name of Parent or Legal Guardian Making this Request:** ______________________

AUTHORIZATION FOR RELEASE OF INFORMATION TO (THE RECIPIENT OF THESE RECORDS):

Name of Person or Organization: ____

Street Address: ____

City: ____________________ **State:** ______ **Zip:** ________ **Telephone:** ______________

FOR SECURE, ELECTRONIC DELIVERY OF RECORDS (IN LIEU OF MAILING), PROVIDE A DELIVERY EMAIL ADDRESS BELOW:

Email Address: ____________________________________

You will be charged for the production of all Medical Records not to exceed the amount allowed by Georgia Statute §31-33-3. Unless otherwise indicated below, medical record requests are processed by HealthPort. They charge for each page copied and will invoice you directly.

☐ **Treatment/ Record Summary** ***(includes problem list, immunization record, growth chart, and most recent checkup)***

☐ **Complete Medical Record** ☐ **Other or Details, (please specify):** ______________________

☐ **All/ Complete Records for a specified range of dates: From** ____________ **to** ____________

SPECIFIC PURPOSE OF PHI DISCLOSURE REQUEST:

☐ **Patient/ Individual Request** ☐ **Transferring Out/ Leaving Practice** ☐ **Insurance** ☐ **Referral**

Other Purpose (please specify):____

I understand that this PHI may include information on diagnosis/ treatment related to psychiatric or psychological conditions , abuse, disability, alcohol or drug dependency, AIDS, HIV status, pregnancy, and/or sexually transmitted diseases. By signing below, I specifically authorize this information (if applicable) to be included in this release.

PERSON SIGNING AND AUTHORIZING THIS PHI RELEASE/ RELATIONSHIP TO PATIENT (*check one*):

☐ **Patient** ☐ **Parent / Legal Guardian** ☐ **Other (please specify)** ______________________

PRINTED NAME:__________________________ **SIGNATURE:**__________________________

DATE OF THIS REQUEST: ______________________

EXPIRATION DATE: This authorization will expire on *(indicate specific date or event)* : ________________

If a date or event is not indicated, this authorization shall automatically expire (90) days from the original date of request.

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