MEDICAL RECORDS (PHI) RELEASE FORM

COBB PEDIATRICS

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 copying of all Medical Records not to exceed the amount allowed by Georgia Statute §31-33-3. We will 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 , 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.

COBB PEDIATRICS|3405 DALLAS HWY SW, #300|MARIETTA, GA 30064| Tel 770.425.5331 | Fax 770.425.0799