MEDICAL RECORDS (PHI) RELEASE FORM

COBB PEDIATRICS

Active patients can quickly access free, electronic copies of their office visits and more via the Patient Portal. Log in to your account at www.cobbpeds.com.

For all other paper or electronic 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:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Telephone:** _____

f 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: _____

: _____ **State:** _____ **Zip:** _____ **Telephone:** _____ **Fax:**_____

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

Email Address: _____

A $30.00 processing and administration fee will apply to all medical records requests. This fee must be paid in advance. After submitting this form, please contact our office at 770-425-5331 to make payment.

☐ **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