Pediatric Development Center of Atlanta, LLC
2300 Highlands Parkway Suite 150
Smyrna, GA 30082
770-433-2300

AUTHORIZATION FOR THE RELEASE OF HEALTHCARE INFORMATION*

I, ____,
(insert the name of the Parent)

on behalf of my child __________________________ (insert child's legal name) authorize the Pediatric Development Center of Atlanta, LLC, to disclose healthcare information relating to
____
(insert the word "all" or describe the limited information to be released)

to the following individuals or entities ____
____
(insert the names of the individuals or entities to whom the healthcare information is to be released)

for the following purposes ____
____
(insert the purpose for which the information is being released)

This authorization [may] [may not] (cross out one of the choices) be used for the release of additional information to the same person or entities for the same or related purposes.

This authorization will remain in effect until ________________________________.
(insert the date after which the authorization will no longer be valid)

You, the parent, may refuse authorization to disclose all or some healthcare information but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences.

You, the parent, may revoke this authorization at any time by executing a written revocation, subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation. If you do revoke this authorization, that action could result in the denial of health benefits or other insurance coverage or benefits.

You, the parent, must deliver the revocation of your authorization to us by hand, by certified mail or by express delivery service.

You are entitled to a copy of this authorization.

__________________ ____
Date Signature of Parent

* This form is required by 45 C.F.R. §164.508(c) and O.C.G.A. § 31-33-2.