Sibley Heart Center Cardiology
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Atlanta, Georgia 30341
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Children's Healthcare of Atlanta | Sibley Heart Center CARDIOLOGY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Note: All fields marked with an asterisk (*) are required fields.

_____ _____
***PRINT PATIENT'S Full Name** ***PATIENT'S Date of Birth**

_____ _____
***PRINT name of Parent/Legal Guardian or Patient if 18 or older** ***DAY Phone Number & Area Code**

***Check (☐) one. I am the ☐ Patient (must be 18 year of age or older) ☐ Parent or ☐ Legal Guardian with custody (please state relationship to custodianship) _____**

***☐ Fax ☐ Mail ☐ Verbal – to discuss PHI**

TO: _____
***PRINT name of Individual(s) or Agency**

_____ **Telephone#_____**
***PRINT (Street Address or Box Number)**

_____ **Fax # _____**
***PRINT (City, State and Zip Code)**

- **I place no limitations on history or illness (including HIV and/or AIDS, genetic, drug dependency or psychiatric information) or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse or psychiatric disorders.**
- **I authorize the inspection of the above information by the above named agency/person and/or to the furnishing of a photostat or other copies.**
- **I understand that unless otherwise limited by state or federal regulation, I may withdraw this consent at any time by submitting my withdrawal request in writing. The withdrawal of this authorization does not affect any health information disclosed prior to Sibley Heart Center Cardiology receiving a written notice of withdrawal.**
- **I hereby release Sibley Heart Center Cardiology and its officers, directors, agents and employees from any liabilities, responsibilities, damages, losses, and claims which might arise from the release of the information authorized above.**
- **In furtherance of this authorization, I do hereby waive all provisions of the law and privileges related to the disclosures herby authorized.**
- **I hereby acknowledge that I have read (or had someone read to me) the above statements, and that I fully understand the above statements, and do expressly and voluntarily authorize the disclosure of this medical information to the individual or agency named above.**
- **I hereby authorize _____to release my records to the above address.**

THE FOLLOWING INFORMATION IS TO BE RELEASED: Check (✓) Correct Document (s):
Records Distributed: ☐ CD (when available*) ☐ Paper

☐ Clinic Letter ☐ EKG ☐ Echo ☐ Laboratory Reports ☐ Other (specify) _____
_____

*Purpose for which this release is being requested is:
☐ Continuing Medical Care ☐ Legal Action/Review ☐ Insurance Reimbursement
☐ Others (Specify) _____ ☐ Undeclared (at the request of the below signed)

Any disclosure of medical information by the recipient(s) is prohibited except when implicit in the purpose of this authorization.

*This authorization expires _____ (insert applicable date or event or insert "no expiration designated") or in 6 months (12 months for school requests), whichever is shorter, and no further use/disclosures as described above may be made after the expiration. Authorizations apply only for medical records for specified treatment dates prior to and on the date of signature, unless otherwise specified.
Specified exceptions for future-dated releases are: ☐ School ☐ Other _____

***Signature: _____ *Date: _____**

Internal Use Only

☐ **Faxed** ☐ **Mailed** ☐ **Pick-up/Called**: _____ **Date:** _____