AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS *TO* COVENANT CARE PEDIATRICS

Patient Last Name	First Name	MI	Date of Birth
Street Address	City	State	Zip

I authorize release of medical records for patient care purposes FROM:

Practice/Provider Name: ____________________

Practice Address: ____________________

Practice Phone #: ____________________ Practice Fax #: ____________________

Please send records TO Covenant Care Pediatrics:

**** Please send growth chart/data, immunization records, problem list/summary, and either last well visit or last two years of records.**

Secure e-mail **pdf**	**Fax**	**By mail** **USB drive, CDROM, paper**
ccpoffice@protonmail.com	770.474.0566	Covenant Care Pediatrics 245 Country Club Drive Suite 200A Stockbridge, GA 30281

Parent/Guardian name (or patient if 18+ years old)	Relationship to child
Email	Phone
Signature	Date

HIPAA Notice: According to the HIPAA Privacy Rule, patient consent or authorization is not required for transfer of records for treatment purposes. The Privacy Rule states that a covered entity "is permitted to use or disclose protected health information" for "treatment, payment, or health care operations," without that individual's authorization. It further states that providing health records to another health care provider for treatment purposes "can be done by fax or other means." §§164.502(a)(1)(ii), 164.506(a).

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Inspiring lifelong health, hope, and wellbeing

Rev. 06/22