ROCKDALE PEDIATRICS HEALTHCARE
2020 HONEY CREEK PKWY
CONYERS, GA 30013
PHONE: (770) 922-0553/ FAX: (770) 922-6882

AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

Patient Name:_____
Address:_____ Social Security #_____-_____-_____
City:_____ State:_____ Zip:_____
Date of Birth:___/___/_____ Home Phone:_____ Cell Phone:_____

By signing this form, I authorize Rockdale Pediatrics Healthcare, P.C. to use, release, disclose or obtain the protected information described below:

Name & Address of person and/or Organization (Please mark one) *REQUIRED!*

- ☐ From whom information should be obtained
- ☐ To whom information should be sent

Doctor:_____ Name of Practice:_____
Address:_____ City:_____ State:_____
Zip:_____ Phone #:_____ Fax #:_____

Description Of Health Information To Be Disclosed

- ☐ Complete Medical Records (Please specify dates of service)_____
- ☐ Partial Medical Records Please specify records below)

Information	Dates
☐ Well Visits & Shot Records	_____
☐ Office Notes	_____
☐ Lab Results	_____
☐ X-Rays	_____
☐ Other (Please specify and include date of service)_____	

Unless I request in writing otherwise, I understand that this authorization will expire on _____ (Insert expiration date or event). If I do not enter an expiration date or event, this authorization will expire in 90 days from the date on which I signed this authorization.

I understand that his information authorized to be released or obtained shall include, but not limited to infectious or contagious disease information including HIV or AIDS related evaluation diagnosis, or treatment; information about drug or alcohol abuse or treatment, and/or psychiatric or psychological information. I waive any privilege pertaining to some confidential information.
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so on writing and present my written revocation to Rockdale Pediatrics Healthcare, P.C. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.
I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.
I understand that federal and state laws allow a fee to be charged for the copying of patient records a I will be responsible for the payment of such fees.

_____ _____
Signature of Patient (or guardian) Date
_____Relationship to patient