AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Patient name(s) & Dates of birth: _____
_____
_____

I request that River Rock Pediatrics release my or my child's (children's) Individually identifiable medical record(s):

_____Immunizations only _____Mental Health Records
_____All Medical Records _____Genetic Test Results
_____Drug/Alcohol Abuse _____HIV Test Results
_____Only Medical records related to: _____

Please check **one** of the following:

☐ Please email record(s) to me at_____ or

☐ Notify me when ready for pick up at phone: _____ or

☐ Mail records (fee required per record prior to mailing) to me or new Provider:
_____

_____

This Authorization will expire: _____ (date/event)

I understand that I may revoke or modify this authorization at any time by notifying River Rock Pediatrics in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by River Rock Pediatrics in reliance on this authorization.

Signed:_____Date:_____

(If not signed by patient please indicate relationship):_____