

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

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

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

- | | |
|--|--|
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Mental Health Records |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Genetic Test Results |
| <input type="checkbox"/> HIV Test Results | |

Please check ONE of the following:

Email record(s) to me at: _____
 Mail record(s) to me at: _____

Fee for emailing records is \$25 per record payable in advance by Zelle or check payable to Randall Hepworth. Fee for mailing records will include additional per page charge and postage fee which will be emailed to you after release of records is obtained. Mailed records take at least an additional week after payment is received.

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 _____

(Relationship if patient is minor) _____