AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

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

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

____All Medical Records ____Mental Health Records

____Drug/Alcohol Abuse ____Genetic Test Results

____HIV Test Results

Please check ONE of the following:

____Email record(s) to me at:__________________________________

Fee for emailing records is $25 per record payable in advance by credit (faster) or check payable to Randall Hepworth.

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)_____________________________