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):

____All Medical Records

____Drug/Alcohol Abuse

____HIV Test Results

____Mental Health Records

____Genetic 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 credit (faster) or check 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)_____