Rockdale Family Practice, P.C.
Authorization for Release of Information – Compound Release

Patient Name: _____ Date of Birth: _____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. **Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent.** If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below. I authorize Rockdale Family Practice, P.C. to release my medical and/ or billing information to the following individual(s):

***Check all that apply**

Name: _____ Relation to Patient: _____ ☐ Medical ☐Financial

Name: _____ Relation to Patient: _____ ☐ Medical ☐Financial

Name: _____ Relation to Patient: _____ ☐ Medical ☐Financial

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in the document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subjected to redisclosure by the recipient and may no longer be protected by federal law or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Signature of Patient: _____ **Guardian:** _____

Today's Date: _____/_____/ _____ **Relationship to Patient:** _____