Rockdale Family Practice, P.C.
2020 Honey Creek Parkway S.E, Conyers, GA
Main: (770) 929-0813 Fax: (770) 922-8653

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth ___/___/___

Address_____

City, State, Zip _____Phone _____

At my request, _____ may release the following information:
(Name of the entity)

Phone number:_____ and/or Fax number:_____

- ☐ Entire record
- ☐ Office visit notes
- ☐ X-Ray, Diagnostic Studies, Lab results
- ☐ Other (Please specify)
- ☐ Financial records
- ☐ Medical records from _____ to _____

Entity or person who will receive the information:

Name: **Rockdale Family Practice**

Address: **2020 Honey Creek Pkwy**

City, State, Zip: **Conyers, Georgia 30013** Phone: **770-929-0813** Fax: **770-922-8653**

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

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 this 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 subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ _____

Signature of Patient or Personal Representative Date

Revised December 2014