



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, Rockdale Family Practice may release the following information:

- 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: _____

Address _____

City, State, Zip _____ Phone _____ Fax _____

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