AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Patient: _____ Date of Birth: _____

Physician Name and/or Hospital Name: _____

Hospital/Physician Phone Number: _____ Fax Number: _____

1. I hereby authorize the use or disclosure of the above-named individual's health information as described below.
2. Rockcastle Pediatrics & Adolescents, and/or designee is authorized to make this disclosure.
3. The type of information to be used or disclosed is as follows (check appropriate boxes and include other information where indicated)

___Complete Copy of Health Records
___History and Physical(s)
___X-Ray Film(s)
___X-Ray Report(s)
___Immunization(s)
___Discharge Summary
___Operative Report(s)
___Laboratory Report(s)
___Other (please specify) _____

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency (AIDS), or human immunodeficiency (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. The information identified above may be used or disclosed to the following individuals or organizations: **Rockcastle Pediatrics and Adolescents**
6. This information for which I am authorizing disclosure will be used for the following purpose:
___ My personal records ___ Sharing with other health care providers as needed
___ Other (please specify): _____
7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Department. I understand that the revocation will not apply to information that already has been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
8. This authorization will expire in one (1) year unless otherwise specified.
9. I understand that once the above information is disclosed it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
10. I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to healthcare treatment.

_____ _____ _____
Signature of patient or legal representative Relationship to patient Date

_____ _____
Signature of Witness Date

Rockcastle Pediatrics & Adolescents
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