AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Medical Records may be accessed through the Patient Portal at no cost, a fee of $20 may apply if produced by our office. Fill out form in its ENTIRETY; if any section is incomplete, this form may be invalid and the request may not be processed.

Patient Last Name: _____ **Patient First Name:** _____ **DOB:** _____

Address: _____ **Phone#:** _____

_____

___ **Release To:** **Rivertown Pediatrics, PC**
2416 Capstone Court
Columbus, GA 31909
P: 706-327-1281
F: 706-327-1159

From: _____
_____
_____
Phone: _____
Fax: _____

___ **Release From:** **Rivertown Pediatrics, PC**
2416 Capstone Court
Columbus, GA 31909
P: 706-327-1281
F: 706-327-1159

To: _____
_____
_____
Phone: _____
Fax: _____

Purpose Information Requested:
___ **Continuing Medical Care**
___ **Insurance Claims/Application**
___ **Disability Determination**
___ **Personal**
___ **Change of Primary Care Physician (PCP)**
___ **Change of Insurance**
___ **Other** _____
___ **Moving/New Address:** _____

Release By:
___ **Mail**
___ **Pickup**
___ **Fax:** _____

ATTENTION: Please review carefully. If information is missing the request may not be processed.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older, and lacks capacity to sign,** a legal authorized person may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ___ Legal Guardian or Conservator ___ Health Care Agent
- **If patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exist under state or federal law. Please indicate your relationship:
  ___ Parent ___ Legal Guardian
- By signing this authorization, I authorize the use and disclosure of the protected health information requested to include mental health, HIV and STD information. I understand that the information may be re-disclosed by the recipient and may no longer be protected by the HIPAA privacy rule. I have the right to revoke this authorization, except to the extent that Rivertown Pediatrics has acted in reliance upon this authorization.

_____ _____
Signature **Date (Authorization expires in 6 months)**

_____ _____
Printed Name **Witness**

INTERNAL USE ONLY

___ Faxed ___ Mailed ___ Picked Up Date: _____ Employee: _____