



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 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: _____