

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name/DOB _____

Patient Name/DOB _____

Patient Name/DOB _____

Patient Address _____

City _____ State _____ Zip Code _____

Name of Health Care Provider (release records from):

SAGE HILL PEDIATRICS
DR. KEVIN J. RODBELL
1799 BRIARCLIFF ROAD NE, SUITE X
ATLANTA, GA 30306
PHONE: 404-745-4578
FAX: 404-745-4579

Type of Medical Records Released:

- All/Complete Records this range of dates From _____ to _____
- Treatment Summary/Abstract (includes problem list, immunization record, growth chart, and most recent well visit)
- Complete Billing Record
- Progress Notes
- Pathology Reports
- Diagnostic Reports
- Specialist Reports
- Immunization Record
- Growth Charts
- Other (please specify) _____

I grant permission for my child's/children's medical records to be released to:

Name of Person or Organization _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Person signing and authorizing PHI release/relationship to patient (please check one):

- Parent
- Legal guardian
- Patient/Self
- Other, please specify _____

Printed Name: _____ Signature _____

Date of This Request _____

EXPIRATION DATE: This authorization will expire on (indicate specific date) _____

If a date is not indicated, this authorization will automatically expire 90 days from original date of request.