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.