

**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) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**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:

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

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.