

ROCKDALE MEDICAL CENTER RELEASE OF INFORMATION AUTHORIZATION / REQUISITION FORM (Circle One)

Section A: This section to be completed by the patient.

Patient Name:		Medical Record #	
Address:		Date of Birth:	
		Other:	
Name of Disclosing Hospital/Provider	Facility Name:	Rockdale Medical Center	
	Address:	1412 Milstead Avenue	
	City/State/Zip:	Conyers, GA 30012	
	Phone #:	770-918-3372	
Name of Recipient	Requestor Name :		
	Address:		
	City/State/Zip:		
	Phone:		

Date(s) of Service: _____

List specific description of information to be released:	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Imaging Reports	<input type="checkbox"/> Physician Orders	<input type="checkbox"/> All Records
	<input type="checkbox"/> Billing Records	<input type="checkbox"/> EKG's	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Outpatient Records	<input type="checkbox"/> Other _____
	<input type="checkbox"/> UB04	<input type="checkbox"/> Emergency Records	<input type="checkbox"/> Medication Records	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> _____
	<input type="checkbox"/> Itemized Bills	<input type="checkbox"/> Face Sheet	<input type="checkbox"/> Nursing Records	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> _____
	<input type="checkbox"/> Consultation	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Sgy/Proc Report	<input type="checkbox"/> Acctg of Disclosure	<input type="checkbox"/> _____

Do you want the Hospital/Clinic to release your psychotherapy notes (if any) to the person or facility you have listed above? (Circle One) YES NO _____(initial here)

Describe the purpose /reason for this request: _____

Section B: Must be completed by the patient for all authorizations:

The patient or the patient's representative must read/acknowledge the following statements:

1. I understand that the persons hereby authorized to use/disclose information will not condition treatment or payment on my providing this authorization.
2. I understand that this authorization will expire on ____/____/____. **(If no date is written, this authorization will expire one year from the date on which it is received by the hospital.)**
3. I understand that information used or disclosed to any entity other than a health plan or health care provider may be subject to redisclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 C.F.R. 160 and 164.
4. I understand that I may revoke this authorization at any time by notifying the hospital in writing, except to the extent the hospital has already taken action in reliance on the previous authorization.
5. I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.
6. I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.
7. I understand that I may refuse to sign this authorization and in doing so, understand refusal to sign this authorization will not affect my treatment

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary.

(Signature of Patient or Patient's representative)	(Date)
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(If patient representative, please print name below and provide proof/documentation the representative has which provides the authority to act for the patient. _____)

FOR OFFICE USE ONLY:

Verified :	Yes	No	License #	
By:			SS #	
Signature:	Yes	No	Other:	

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9.23.13



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