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:	❑ Anesthesia	❑ Discharge Summary	❑ Imaging Reports	❑ Physician Orders	❑ All Records
	❑ Billing Records	❑ EKG's	❑ Laboratory	❑ Outpatient Records	❑ Other _____
	❑ UB04	❑ Emergency Records	❑ Medication Records	❑ Pathology Report	❑ _____
	❑ Itemized Bills	❑ Face Sheet	❑ Nursing Records	❑ Progress Notes	❑ _____
	❑ Consultation	❑ History & Physical	❑ Sgy/Proc Report	❑ Acctg of Disclosure	❑ _____

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)

(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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