RODNEY N. KREIDER, MD, PC
AUTHORIZATION FOR USE/RELEASE OF
HEALTH INFORMATION

By signing this form, I authorize RODNEY N. KREIDER, MD to Use, Release or Disclose the Protected Health Information described below:

Name of Person and/or organization to which information should be sent:

RODNEY N. KREIDER, MD, PC
1233 EAGLES LANDING PKWY., STE. I
STOCKBRIDGE, GA 30281
TELEPHONE: (770)507-4144 FAX :(770)507-1001

Please send this information on:

PATIENT'S NAME AND DATE OF BIRTH_____

ADDRESS_____

TELEPHONE NUMBER_____ **DATE**_____

Purpose of Disclosure: _____

Expiration Date: _____

I authorize the following information to be sent to the above address:

_____**COPIES OF ALL MEDICAL RECORDS FOR THE PERIOD OF ____ TO_____**
_____**COPIES OF THE INFORMATION DESCRIBED BELOW FOR PERIOD ___ TO___**
_____**HISTORY & PHYSICAL EXAM.**
_____**LAB, X-RAY, ETC. REPORTS**
_____**REPORTS FROM OTHER PHYSICIANS**
_____**OTHER (PLEASE SPECIFY)** _____

I understand that this information may include a history of AIDS, Sexually Transmitted Diseases, HIV Infection, Behavioral Health Service/Psychiatric Care, Treatment for Alcohol and/or Drug Abuse, or similar conditions.

The following should not be released, even if occurring during dates above:

_____

I understand that there may be information in these records that I would not want released. I have been provided a copy of Rodney N. Kreider, MD "Notice of Privacy Practices" and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, and disclosure of my health information with Rodney N. Kreider, MD Privacy Officer or other appropriate office personnel.
I understand that Rodney N. Kreider, MD assumes no responsibility for the use or misuse by others of my Health Information disclosed under this authorization. I release Rodney N. Kreider from all legal liability that may arise from this authorization.

PARENT OR LEGAL GUARDIAN'S SIGNATURE_____

RELATIONSHIP TO PATIENT_____

DATE_____

The patient or their representative may revoke this authorization by notifying in writing Rodney N. Kreider, MD designated privacy officer. Federal Law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the privacy rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to re-disclosure by the recipient.

PREVIOUS PHYSICIAN_____
ADDRESS_____
TELEPHONE & FAX NUMBER_____