CAROLINA PEDIATRICS

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AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I _____, hereby authorize Carolina Pediatrics

To Release □ TO: _____ **OR obtain** □ medical records FROM:

Office: _____ _____

Phone: _____ _____

Fax:_____ _____

DO NOT FAX MORE THAN 50 PAGES

(Physician/Physician practice/hospital/family member, etc.):

Patient Name: _____Date of Birth: _____
Patient Name: _____Date of Birth: _____
Patient Name: _____Date of Birth: _____

Please send the following information:

__ Discharge Summary
__ History & Physical
__ Consult Reports
__ Progress Notes
__ X-ray
__ ER Reports
__ Operative Report
__ Lab Reports
__ Other_____

PURPOSE OF RELEASE:

____Insurance Change ____Change of Physician ___Moving____ Personal

If other, please provide a brief description:

_____

Carolina Pediatrics does not accept new patients who do not vaccinate

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to Carolina Pediatrics. I understand that a revocation is not effective to the extent that Carolina Pediatrics has relied on the use of disclosure of the protected health information. I also understand that my records are protected under the Federal Confidentiality Regulations and cannot be further disclosed without my written consent.

I understand that there may be a charge for obtaining the requested information. By signing, I agree to the processing terms and recognize that I am responsible for all related processing fees. Information on the charge can be obtained by contacting the medical records department noted at the top of this form.

_____ _____

(Parent/Legal Guardian/Auth. Rep) **Date**

Address:_____ **City,State,ZipCode:**_____

Phone #_____