Chapel Hill Pediatrics & Adolescents
205 Sage Rd Suite 100, Chapel Hill, NC 27514
(P) 919-942-4173 (F) 919-933-3473

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

______________________________________	______________________________________
(Print Patient's Full Name)	**(Birth Date: m/d/y)**
______________________________________	______________________________________
(Street Address)	**(Preferred Name)**
______________________________________	______________________________________
(City, State, Zip Code)	**(Phone Number(s))**

At the request of the individual, I ______________________________, do hereby authorize **CHP&A** to release:
(Parent/Patient if over the age of 12)

_________Progress notes _________ Pathology Reports_________ Other Doctor Notes _________ All Records
_________ Lab Reports _________OB/GYN Notes _________ Radiology Reports _________ Hospital Notes
_________ ECG/EEG/Cardio Other:____

I do / Do Not: Authorize release of information related to AIDS/HIV, or any other communicable diseases, psychiatric care, and/or psychological assessments, along with treatment for alcohol and/or drug abuse.

Information Release To: ____
(Name: Physician, Hospital, Agency, Etc.)

____
(Street Address)

____
(City, State, Zip Code)

Purpose of disclosure: _________Referral to Specialist _________Insurance _________Worker's Comp
_________ Legal Investigation _________ Disability _________ Personal _________Relocated

_________ Other (specify):____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sigh the authorization. I understand that I may REVOKE this authorization at any time.

Reason for transferring:____

Please provide a current phone number in case we need to contact you:______________________________

____ **Date:**_________________
*****Signature of patient if over the age of 12*****

____ **Date:**_________________
Signature of parent or guardian or personal representative of patient's estate

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****** If your child is over the age of 12 they must sign the release in order for Chapel Hill Peds to release their records.***

NOTE: **There will be an $10.00 charge for records. You may bring your own flash drive, OR a 1 gigabyte (GB) drive is available for purchase in our office for $12.00. records are exported to an Adobe PDF file format.**