AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
(Print Patient's Full Name) (Birth Date: mm/dd/yyyy)

_____ _____
(Street Address) (Cell Phone Number)

_____ _____
(City, State, Zip Code) (Home Phone Number)

At the request of the individual, I _____, do hereby authorize:
(Parent/**Child if over 12**)

_____
(Name of Facility/Previous Doctor's Office)

_____
(Address of Facility/Previous Doctor's Office including State and ZIP Code)

_____
(Phone/Fax Number of Facility/Previous Doctor's Office)

To release:
___Progress notes___ Pathology Reports___ Other Doctor Notes ___ Lab Reports___ OB/GYN Notes ____ All Records
___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: **Chapel Hill Pediatrics and Adolescents, P.A.**
205 Sage Road, Suite 100
Chapel Hill, NC 27514
(P) 919-942-4173 (F) 919-933-3473

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 affect 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 sign the authorization. I understand that I may REVOKE this authorization at any time.

Reason for transferring:_____

I understand that I am solely responsible for any fees incurred in copying and/or obtaining these records.

_____ **Date:** _____
Patient signature if over 12 yrs.

_____, _____ **Date:** _____
Signature of individual or guardian or personal representative of patient's estate. **Relationship to patient**