Pediatric Partners
Where care grows.

5904 Six Forks Road Suite 111
Raleigh, NC 27609
919-787-9555

Authorization for Release of Medical Information

Child's Full Name:_____ Date of Birth:_____

Child's Full Name:_____ Date of Birth:_____

Child's Full Name:_____ Date of Birth:_____

_____
(Street Address)

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

I, _____, hereby authorize the use, release, and/or disclosure of Protected Health information as described below. I understand that Pediatric Partners assumes no responsibility for the use or misuse by other of my health information disclosed under this authorization. I understand there will be a fee incurred of $15.00 for release of medical records. Please allow fourteen (14) business days for all medical record requests.

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infections; behavioral health/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

_____All Medical Records for the period of_____to_____

_____ Immunization Records only

Release From: _____ Release to:_____

Address:_____ Address:_____

_____ _____

Phone:_____ Phone:_____

Fax:_____ Fax:_____

Reason for transfer/disclosure:_____ Moving _____Transfer_____Patient Request_____Legal_____

Patient/parent/Guardian Signature:_____ Date:_____

Patient/parent/Guardian printed name:_____