

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print Patient's Full Name)

(Birth Date: m/d/y)

(Street Address)

(Social Security 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)

(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 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 sign 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: _____

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

Signature of individual or guardian or personal representative of patient's estate **Date:** _____