Raleigh
1921 Falls Valley Drive
Raleigh, NC 27615
Phone: (919) 872-0250
Fax: (919) 848-3054

Garner
1405 Timber Drive East
Garner, NC 27529
Phone: (919) 779-6423
Fax: (919) 662-2021

Raleigh Pediatric Associates

Authorization to Use/Release/Disclose Health Information

Section A: (Must be completed for all authorizations)

I, _____, understand that Raleigh Pediatrics is authorized by me to use, release, and/or disclose the Protected Health Information (PHI) as described below. I understand the information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy regulations.

****IF THIS REQUEST IS FOR RECORDS TO BE SENT TO RALEIGH PEDIATRICS, THIS FORM IS TO BE MAILED OR FAXED BY THE PARENT AND NOT BY RALEIGH PEDIATRICS.**

Patient's Name: _____ **Date of Birth:** _____

RELEASE FROM:
Name: _____
Address: _____
_____

RELEASE TO:
Name: _____
Address: _____
_____

I authorize the following information to be sent to the above address: (Check all that apply)

☐ Copies of Medical Records for the Period: ___/___/___ to ___/___/___
Mo Day Year Mo Day Year

☐ Copies of information described below for the Period: ___/___/___ to ___/___/___
Mo Day Year Mo Day Year

☐ History & Physical Examination

☐ Reports from other physicians

☐ Lab, X-Ray, etc. reports

☐ Other (Please Specify) _____

☐ The following information should **not** be released (Please specify**)** _____

Reason for transfer/disclosure: _____

If transferring for insurance reasons, please specify which insurance company: _____

Section B: (Must be completed for ALL Authorizations)

I understand that:

- I may revoke this authorization at any time by notifying the Practice's HIPAA Privacy Officer in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. I may request or copy the protected health information to be used or disclosed.
- This authorization will expire ten years from today's date unless otherwise specified.
- Raleigh Pediatric Associates assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization.

Patient/Parent/Guardian Signature: _____ **Date** _____

PLEASE ALLOW 14 BUSINESS DAYS FOR ALL MEDICAL RECORD REQUESTS

Office use only: Patient Chart # _____ Date Information Disclosed: ___/___/___ Initials _____
HIPAA Officer review (If records are being inspected by patient/parent) _____ Date reviewed ___/___/___

Revised: Sept. 17, 2008/mtb