



Raleigh Office: 1921 Falls Valley Drive, Raleigh, NC 27615
Garner Office: 1405 Timber Drive East, Garner, NC 27529

Phone: 919-872-0250
Phone: 919-779-6423

Fax: 919-848-3054
Fax: 919-662-2021

Authorization to Use/Release/Disclose Health Information

PLEASE ALLOW 14 BUSINESS DAYS FOR ALL MEDICAL RECORDS REQUESTS.

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 re-disclosure by the recipient and no longer protected by the Privacy regulations.

- ❖ If this request is for any patient 18 years or older, the form must be signed by the patient.
❖ If the patient is in the custody of the county, a representative of the county (Ex: social worker) must complete this release form. (Not the foster parent)
❖ If the request is for records to be sent to Raleigh Pediatrics, this form is to be mailed or faxed by the parent and not from Raleigh Pediatrics.

Patient's Full Name: _____ Date of Birth: _____ Best Contact #: _____

Release From:

Name: _____
Address: _____

Release To:

Name: _____
Address: _____

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

- ___ Copy of Complete Medical Records (specify dates) Date: ___/___/___ to ___/___/___
___ Copy of Information described below Date: ___/___/___ to ___/___/___
___ History & Physical Exams
___ Reports from other Physicians (Specialist)
___ Labs, X-rays, etc. reports
___ Other (Explain): _____
___ The following information should NOT be released (Explain): _____

Purpose of use or disclosure:

- ___ Transferring to another provider ___ Physician/Staff Request
___ Patient/Parent Request ___ Moving

Other (Please explain): _____

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: _____ Relationship: _____ Date _____

Office Use Only:
Patient Chart #: _____ Date Information Disclosed: _____ Initials: _____
HIPAA Review Officer (if records being inspected by patient/parent): _____ Date reviewed: _____