Raleigh Pediatric Associates

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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 – Please provide forwarding address***: _____

_____

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: _____

Revised: 7/15/08/mtb; 10/19/10/tew; 8/11/16/am; 2/16/17/sgb; 6/2017/pg; 9/2017 sgb/mn