

GARNER OFFICE

1405 Timber Dr East, Garner, NC 27529  
TEL 919-779-6423 FAX 919-845-6892



RALEIGH OFFICE

1921 Falls Valley Dr, Raleigh, NC 27615  
TEL 919-872-0250 FAX 919-845-7753

# Authorization to Use/Release/Disclose Health Information

**PLEASE ALLOW 10 BUSINESS DAYS FOR ALL MEDICAL RECORDS REQUESTS.**

I hereby authorize the 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 the patient is 18 years of age or older, this form must be completed and signed by the patient.
- ❖ If the patient is in the custody of the county, this form must be completed and signed by a representative of the county.

PATIENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
\_\_\_\_\_

**Complete this section to release records FROM RALEIGH PEDIATRIC ASSOCIATES.**

I authorize *Raleigh Pediatric Associates* to release medical records to the following.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Email address (if for personal use) \_\_\_\_\_

**Complete this section for records to be SENT TO RALEIGH PEDIATRIC ASSOCIATES.**

I authorize the following to release medical records to Raleigh Pediatric Associates.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_ Garner Office FAX: 919-845-6892 \_\_\_\_ Raleigh Office FAX: 919-845-7753

**\*\* We prefer records transferred in electronic format. \*\***

**Information to disclose:** Immunizations, growth charts, problems lists including applicable specialist notes, and the last 3 years of well exams. To request additional information, please list here: \_\_\_\_\_

**Purpose of disclosure:**

\_\_\_\_ Transferring to another provider. If so, please state reason: \_\_\_\_\_

\_\_\_\_ Moving. New address: \_\_\_\_\_

\_\_\_\_ Physician/Staff request. (Exchange of information – not transferring out)

\_\_\_\_ Personal Use. Please provide your email for receipt of records. \_\_\_\_\_

\_\_\_\_ Other, please be specific: \_\_\_\_\_

*I understand that:*

- ✓ I may revoke this authorization at any time by notifying the practice's HIPAA Privacy Officer in writing.
- ✓ This authorization will expire 1 year from today's date unless otherwise specified.
- ✓ Raleigh Pediatric Associates assumes no responsibility for the use or misuse of the health information disclosed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

DATE RECEIVED: \_\_\_\_\_

CHART #: \_\_\_\_\_