AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **CAROLINA DEVELOPMENTAL PEDIATRICS** to release healthcare information of the patient named above to:

Name and Fax #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Parent Signature: _____ Date Signed: _____

Parent Name (Printed) _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

Fax Completed Form to : 919-362-5409