Date_____

Carolina Pediatrics Plus
538 Sandhurst Dr.
Fayetteville, NC 28304
Phone: (910) 321-7337
Fax: (910) 321-0003

Patient Name: _____ DOB: _____

Phone: _____ Relationship to Patient: _____

_____ I authorize Carolina Pediatric to **obtain information from:**

Name/Facility/Provider: _____

Address: _____

Phone: _____ Fax: _____

_____ I authorize Carolina Pediatric to **release information to:**

Name/Facility/Provider: _____

Address: _____

Phone: _____ Fax: _____

Purpose of Disclosure: ___ Transfer of Care ___ Legal ___ Specialist ___ Other: _____

Information to be Disclosed:

___ Specific Time Frame: _____ ___ Other: _____

___ Entire Medical Record ___ Well Checks and Shot Records only

****PLEASE NOTE THAT OUT OFFICE IS UNABLE TO PROCESS MEDICAL RECORDS FROM CD. WE ARE ONLY ABLE TO ACCEPT MAILED OR FAXED RECORDS****

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided on this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed
- The information may contain testing or treatment relating to sexually transmitted diseases.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

_____ I understand that this authorization stays in effect for 1 year from the date of my signature below and that a photocopy of this authorization is granted at the same authority as the original.

OR

_____ I understand that this authorization is valid until ___/___/_____ or until the following event: _____

Patient/ Legal Representative (PRINT): _____ Date: _____

Signature: _____ Relationship to Patient: _____