Carolina Pediatrics
OF THE TRIAD, PA

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please release medical information for the following patient(s):

Name(s) _____ DOB _____

_____ _____

_____ _____

_____ _____

Release From:

Practice/Physician _____

Address _____

_____

Phone # (____)_____

Fax # (____)_____

Release To:

Practice/Physician _____

Address _____

_____

Phone # (____)_____

Fax # (____)_____

For the following purpose:

□ Insurance □ Legal □ Transfer to Family Practice

□ Changing physicians (if choosing this option please let us know why:

_____

□ Other (please specify) _____

Release the following information:

□ Entire medical record
□ Immunizations
□ Growth chart
□ Only records dated from _____ to _____
□ Laboratory results
□ X-ray results
□ Psychiatric notes

**Fee for copying patient records: $20.00 total for one child, $30.00 total for 2 children or more.

I authorize the disclosure of medical information for the above named patient(s). I understand that this authorization is voluntary and may be revoked in writing at any time. I understand that this authorization may be revoked in writing, unless the medical records have already been disclosed. I understand that this authorization includes consent for information that may include substance abuse, mental health, and HIV/ AIDS. I understand that this authorization is valid for 12 months from the date signed.

_____
Signature Date

_____
Print Name Relationship to Patient

_____
Address Phone #

Office Use Only

□ Mail □ Fax □ Pick Up

Date Payment Received _____

Date Processed _____

Processed By _____