



<u>For office use only</u>
<input type="checkbox"/> Mailed
<input type="checkbox"/> Faxed
<input type="checkbox"/> Picked parent/patient
Date Released _____

64 Peachtree Rd, Suite 100 – Asheville, NC 28803 – Phone 828-277-3000 – Fax 828-277-3636

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please read ALL information and instructions before completing and signing the authorization form

Patient's Name (please print) _____ Birth date _____
 Mailing Address _____ City _____ State _____ Zip _____

INFORMATION TO BE RELEASED BY:	INFORMATION TO BE RELEASED TO:
<input type="checkbox"/> ABC Pediatrics <input type="checkbox"/> Other facility (please list name, address, phone and fax)	<input type="checkbox"/> ABC Pediatrics <input type="checkbox"/> Other facility (please list name, address, phone and fax)

TYPE OF MEDICAL INFORMATION REQUESTED:

- Complete chart-(this includes **all** office notes and immunizations)
 Last physical
 Behavioral/Mental Health
 Immunizations
 Labs
 Specific date(s) _____

* For charts more than 20 pages, a copying fee of \$15.00 will apply*

- REASON FOR REQUEST:**
 Daycare/School
 Referral
 Personal
 Transfer of care to another physician
 Insurance
 Legal review
 Sports

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below.

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, anytime.

Parent or Legal Guardian Signature _____ Date _____