

Growing Up Pediatrics, PA  
8301 Magnolia Estates Drive, Ste. 17  
Cornelius NC 28031  
704 895 9060 phone  
704 895 6494 fax



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## Authorization to Release Medical Records FROM Growing Up Pediatrics

\_\_\_\_\_  
Patient Full Name

\_\_\_\_\_  
Birth Date (Mo/Day/Year)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Phone (Cell)

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone (Other)

**Release Information From:**

**Release Information To:**

Growing Up Pediatrics, PA

Name of Facility, Person, Company

\_\_\_\_\_  
Name of Facility, Person, Company

8301 Magnolia Estates Drive, Ste 17

Street Address, City, Zip

\_\_\_\_\_  
Street Address, City, Zip

704-895-9060 (p) 704-895-6494 (f)

Phone

\_\_\_\_\_  
Phone & Fax

**Type of Information to be Disclosed (circle all that apply):**

ALL RECORDS

History & Physical

History & Physical

Vaccine Records

Laboratory Reports

Other : \_\_\_\_\_

I do \_\_\_ or I do NOT \_\_\_ authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV ( Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol.

**Dates of Information to be Disclosed:** From \_\_\_\_\_ To \_\_\_\_\_ (or) All \_\_\_\_\_

**Purpose of Disclosure (circle one)**

**Delivery Method: (only select one)**

Referral to Specialist

Legal Investigation

Regular U.S. Mail ((or) Fax

Personal/Moving

Change of Doctor

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition their treatment of me on whether or not I sign the authorization.

\_\_\_\_\_  
Signature of Individual or Guardian or Personal Representative of Patient's Estate

\_\_\_\_\_  
Print Name of Individual or Guardian or Personal Representative

\_\_\_\_\_  
Date