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

Authorization for Release of Medical Records

Patient Full Name

Birth Date (Mo/Day/Year)

Street Address

Phone (Cell)

City, State, Zip Code

Phone (Other)

Release Information From:

Release Information To:

Name of Facility, Person, Company

Growing Up Pediatrics, PA

Name of Facility, Person, Company

Street Address, City, Zip

8301 Magnolia Estates Dr., Suite 17

Street Address, City, Zip

Phone

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

Phone

Dates of Information to be Disclosed: From _____ to _____ (or) All _____

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

History & Physical

Pathology Reports

Emergency Reports

Vaccine Records

Laboratory Reports

Discharge Summary

Progress Notes

Radiology 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.

Purpose of Disclosure (circle one)

Referral to Specialist

Legal Investigation

Personal/Moving

Change of Doctor

Format (only select one)

Paper (or) CD (or) Fax

Delivery Method: (only select one)

Regular U.S. Mail (or) Pick-Up (or) Fax to _____

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