Authorization to Release Medical Information

Release To:
Hanover Pediatrics
1904 Tradd Ct
Wilmington NC, 28401
Phone: 910- 769-4994
Fax: 910-769-9254

Release From
Name:_____
Address_____
_____
Phone:_____
Fax:_____

Patient Name:_____ **DOB:**_____

1. Information to be released:
☐ **ALL** information ☐ **ALL** Progress notes ☐ Lab Reports ☐ X-ray Report
☐ Electrocardiogram (ECG) ☐ Allergy Records ☐Immunization Records ☐ Other:_____

Special Authorization: Check applicable box(es) and sign immediately below:
By signing below, I authorize the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

NOTE: This release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentially rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse by patient.

Patient's/ Guardian Signature_____ Date_____

2. **RECORDS FROM THE TIME PERIOD:** / / through / /

3. **PURPOSE OF DISCLOSURE:(** Check applicable purpose)
☐ Transfer of Medical Care ☐ Payment of insurance Claim ☐ Legal
☐ Personal ☐ Workers' Compensation Claim ☐ Other_____

4. I understand that this authorization shall be valid for five years. I understand that I may revoke this consent anytime except to the extent that action has already been taken.

5. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

6. The requestor may be provided with a copy of this authorization.

Patient/Guardian Signature:_____ Date:_____
For office use only:
MR#_____ Date:_____ Initials of Staff Member Sending:_____