KidzCare PEDIATRICS

Accessible, Affordable, Quality Care @ Patient Centered Medical Home

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____

DOB:_____/_____/_____

Specific Information to be released:

☐ All Medical Records ☐ Lab Results

☐ Shot Records ☐ Medication Forms

☐ Current Medical Exam / Physical Forms ☐ Other_____

Reason for MR Release: ___Transfer of Care___Moving____Parent Rec. Copy ___PCS___Other

Release To: **Release From:**

_____ _____

_____ _____

Please state how you would like information released:

____Mail (provide address above +50pgs) ____Fax (provide number above -50 pgs)

____Pickup

I DO___**DO NOT**___ authorize the release of portions of the record relating to substance abuse, psychological/psychiatric conditions and/or communicable disease, including AIDS, if present.

I understand that this consent is revocable except to the extent that action has already been taken. This consent will automatically expire 90 days from the date of signature, unless another date is specified below.*

NOTE: Unless otherwise permitted by law, further release of this information is prohibited without my prior consent.

_____ _____

Signature of parent/legal representative Date:

_____ _____

State relationship if other than parent

_____ _____

Signature of Witness Date:

*Authorization not valid beyond _____

Date cannot exceed one year from Date of Signature

5617 Ramsey Street Suite 102 Fayetteville NC 28311
Tel: 910-483-PEDS (7337) Fax: 910-483-0648
www.kidzcare.com
info@kidzcarepediatrics.com

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