



Outgoing Medical Record Release Form

Incomplete releases will not be processed

Patient Name: _____

DOB: _____

Medical Records to:

Name of Office/Individual to receive records

Phone Number

Email Address (if e-mailing records)

Fax Number (if faxing records)

How would you like to receive them?

Choose one:

- ☐ E-mailed ☐ Faxed
☐ Published to Patient Portal (portal eligibility and activation required)

Records requested: (Choose one)

- ☐ Immunization Record and last 3 office visits (no charge)
☐ Complete Medical Record (may be subject to charge)
☐ Other (Please Specify): _____

Purpose of Disclosure:

I authorize the release of medical information to another provider/facility as deemed necessary for my treatment. I further authorize KidzCare Pediatrics to obtain medical information from another provider/facility as deemed necessary in the course of my treatment. This authorization may be revoked by me, in writing, at anytime. Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by HIPAA. My health care and payment for my health care will not be affected by refusing to sign this form. I understand that I may see and copy the information described on this form as requested. I understand there may be a fee for copying medical records as allowed by federal and state law. I understand that it may take 30 days for medical records to be released and that KidzCare Pediatrics may withhold records until the medical record fee is collected.

Pursuant to North Carolina Code, 90-411, a physician may charge a fee for the search and duplication of an electronic medical record. KidzCare Pediatrics charges a flat fee of \$15.00 per request where allowed. This fee must be paid prior to the completion of the request. Failure to remit payment in full at the time of receipt may result in the issuance of a billing statement, for which you will be solely responsible.

I expressly consent to receive text messages from KidzCare Pediatrics at the phone number provided above. I understand these messages may include administrative, billing or clinical updates. I acknowledge that standard text messaging is unencrypted and carries some security risks. I agree that my consent is completely voluntary and is not a condition of receiving medical treatment. I can opt out at any time by replying "STOP" to any text message.

Printed Name of Requestor

Relationship to patient

Patient/Parent/Guardian Signature

Date

Address:

Telephone Number:

This release expires 1 year from signature date above unless specified otherwise in writing.