

AUTHORIZATION TO RELEASE INFORMATION

Capitol Pediatric & Adolescent Center, PLLC

Phone: (919) 782-5273

Fax: (919)-781-8853

I hereby authorize _____ to use or disclose the specific information described below to the parties and for the purposes also described below:

Patient Name: _____ **Date of Birth:** ___/___/___

Description of the specific information to be used or disclosed*:

*Please note we are not able to verify completeness or accuracy of records transferred to Capitol Pediatrics from another practice.

Entire medical record including records from other entities. **I understand that records from other entities may not be the complete records from other facilities, hospitals, or practices.**

Entire Capitol Pediatrics & Adolescent Center, PLLC records Medical Form Completion

Immunization records Medications

Laboratory test results

Entire medical record with the following exceptions: _____

Only these items from the medical record: (include range of dates). _____

This information is being requested for the following purpose(s):

The patient is transferring to another practice.

The patient is being referred to a specialist.

The patient was involved in an accident.

The patient was the victim of a crime.

The patient is participating in a clinical trial.

Other: _____

I understand that:

- I may request or copy the protected health information to be used or disclosed.
- I may revoke this authorization by contacting your office in writing.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer is protected by HIPAA.
- This authorization is valid for the period of one (1) year.

Patient/Parent/Guardian Signature: _____ Date: ___/___/___

Name and address of records recipient: Will Pick Up Please Mail

Name: _____ Phone #: _____

Address: _____ Fax: _____

Office Use Only:

Date Information Disclosed/Transferred: ___/___/___ Chart #: _____

Released by: _____