Terry Brenneman, MD • Melanie Walker, MD • Virginia Schreiner, MD • Kelly Hayes, MD • Nina LeCompte, MD

Authorization for Release of Medical Information

Child's Full Name:_____ Date of Birth:_____

Child's Full Name:_____ Date of Birth:_____

Child's Full Name:_____ Date of Birth:_____

_____

(Street Address)

_____ _____

(City, State, Zip Code) (Home Phone)

I, _____, hereby authorize the use, release, and/or disclosure of Protected Health information as described below. I understand that Pediatric Partners assumes no responsibility for the use or misuse by other of my health information disclosed under this authorization. I understand there will be a fee incurred of $15.00 for release of medical records. Please allow 14 business days for all medical record requests.

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infections; behavioral health/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

All Medical Records for the period of_____to_____ _____ Immunization Records only

Release From: _____

Address:_____

_____

Phone:_____

Fax:_____

Release to:_____

Address:_____

_____

Phone:_____

Fax:_____

Reason for transfer/disclosure:_____ Moving _____Transfer_____Patient Request_____Legal

Patient/parent/Guardian Signature:_____ Date:_____

5904 Six Forks Road • Suite 111 • Raleigh NC 27609 • 919.787.9555 • Fax 919.510.5111