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GROWINGUP PEDIATRICS

Growing Up Pediatrics, PA
8301 Magnolia Estates Drive, Ste. 17
Cornelius NC 28031
704 895 9060 phone
704 895 6494 fax

Authorization for Release of Medical Records

_____ Patient Full Name

_____ Birth Date (Mo/Day/Year)

_____ Street Address

_____ Phone (Cell)

_____ City, State, Zip Code

_____ Phone (Other)

Release Information From:

_____ Name of Facility, Person, Company

_____ Street Address, City, Zip

_____ Phone

Release Information To:

_____ Name of Facility, Person, Company

_____ Street Address, City, Zip

_____ Phone

Dates of Information to be Disclosed: From _____ to _____ (or) All _____

Type of Information to be Disclosed (circle all that apply):

History & Physical	Pathology Reports	Emergency Reports
Vaccine Records	Laboratory Reports	Discharge Summary
Progress Notes	Radiology Reports	Other :_____

I do ___ or I do NOT___ authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol.

Purpose of Disclosure (circle one)

Referral to Specialist Legal Investigation Personal/Moving Change of Doctor

Format (only select one)

Paper (or) CD (or) Fax

Delivery Method: (only select one)

Regular U.S. Mail (or) Pick-Up (or) Fax to _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition their treatment of me on whether or not I sign the authorization.

_____
Signature of Individual or Guardian or Personal Representative of Patient's Estate

_____ Print Name of Individual or Guardian or Personal Representative

_____ Date