23 Sunnybrook Rd. Suite 116
Raleigh, NC 27610
Phone: 919-250-3478
Fax: 919-250-6272

AUTHORIZATION OF DISCLOSURE FOR HEALTH INFORMATION

Patient Name: ________________________________ **Date of Birth:** ____/____/_____
Address: ______________________________________ **Telephone:** _____-_____-_____
____

1. I authorize the use or disclosure of the named individual's health information as described below:
2. The following individual(s) or organization(s) is authorized to make the disclosure

   Choose one: (Send TO ○ Request FROM ⦿)

Provider Name ________________________________ **Telephone:** _____-_____-_____
Address: ______________________________________ **Fax Number:** _____-_____-_____
____

3. The type of information to be used or disclosed is as follows (check and /or include description):
   - ⦿ Complete Medical Record
   - ○ Records only from (date) ___________________ to (date) ____________________
   - ○ Records pertaining to (please describe) ____________________________________
4. I understand that the information in my health record may include information relating to pregnancy, sexually transmitted disease, AIDS, AIDS-related syndrome or HIV testing. It may also include information about behavior or mental health services, alcohol, drug, psychiatric and psychological information.
5. Release records for use by or disclose to the provided:

   Kids First Pediatrics of Raleigh
   23 Sunnybrook Rd. Suite 116 Raleigh, NC 27610
   Telephone: 919.250.3478 Fax: 919.250.6272
6. Disclosed information will be used for the following purposes:
   - ☐ My personal records
   - ☐ Transfer of care, due to dissatisfaction with the practice
   - ☐ Transfer of care due to relocation
   - ☐ Other (please specify) ______________________________________
7. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations.
8. I understand that I have the right to revoke this authorization at any time, by presenting a written revocation to the Privacy Official. I understand that the revocation will not apply to information that has already been released in response to this authorization.
9. This authorization will expire on the following date or event _____________. If I fail to specify an expiration date or event, this authorization will expire in ninety (90) days.
10. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form to assure healthcare or treatment.

Signature _________________________ ______________________ **Date** ____/____/____
Patient or Legal Representative Relationship to patient

To submit this form manually, save the form with your changes added, and email as an attachment to hello@kidsfirstraleigh.com

Submit