



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 Summary
  - 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
  - Switching Practices
  - 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