Release of Medical Information

Burlington Pediatrics Webb
530 West Webb Avenue
Burlington, NC 27217
Telephone: (336) 228-8316
Fax: (336) 227-9750

Burlington Pediatrics West
3804 South Church Street
Burlington, NC 27215
Telephone: (336) 524-0304
Fax: (336) 584-4387

Mebane Pediatrics
943 South Fifth Street
Mebane, NC 27302
Telephone: (919) 563-0202
Fax: (919) 563-0242

Patients Name:_____ **DOB:**_____ **Phone:**_____

Address:_____ **Insurance:**_____

Release Records From:
Name: _____ Phone: _____ Fax: _____

Address: _____
Street City State Zip

Release Records To:
Name: _____ Phone: _____ Fax: _____

Address: _____
Street City State Zip

How would I like the records to be released?
□ Mailed to the Release To address
□ Pick Up by: _____
□ Faxed to provider: _____ _____ _____
Physician Name/Health Care Facility Fax Number Phone Number
□Through oral communication with healthcare providers regarding treatment, care or payment.

Purpose:
□ Continuation of Care □ Insurance □ Legal □ Personal* □ Other (specify) _____

Treatment Date(s):
□ Treatment dates from _____ to _____ (Please be specific) OR □ ALL Treatment Dates

Information to be Released:
□ I would like to **review** onsite, the protected health information for the above dates.
□ I would like copies of specific reports for the treatment dates listed above (check reports below).

□ ENTIRE RECORD □ Summary Information (Discharge Summary, Operative Notes/Procedure Notes, Radiology, Pathology, Laboratory, EKG, ED Notes, Clinic Visits, Consults)	□ History & Physical □ Radiology Reports □ Laboratory Reports □ Pathology Reports □Operative Reports	□ ED Record □ Discharge Summary □ Immunization Records □ PT/OT Notes	□ Discharge Instructions □ Clinic Notes (Ambulatory Progress Notes) □ Other (specify) _____ _____

I Understand That:
- **The information to be released may include a diagnosis or reference to the following conditions: sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV), psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment, and treatment for alcohol and/or drug abuse**
- Without my express revocation, this Authorization will automatically expire one year from the date signed below, unless I request an expiration date less than one year.
- I may **revoke** this authorization in writing at any time, except to the extent that action has already been taken to comply with it. Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation.
- Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Signature: My signature is required to validate this Authorization to release medical information. If I do not sign this authorization, Burlington/ Mebane Pediatrics will still provide treatment and seek payment for services provided. According to the North Carolina General Statues, Health Information Management may charge for copies of medical records.

_____ _____ _____
Signature of Patient/Guardian/Personal Representative Date Relationship (parent, guardian, etc.)

_____ _____
Witness (not necessary for form to be valid) Requested Expiration Date

Mail Request to the applicable entity or Fax to the number listed (If over 15 pages please mail):
*I understand and agree that I am financially responsible for the following fees associated with my request: Copying charges, including the cost of supplies, labor, and postage related to the production of my information. I understand that the charge for this service is $.75 per page for the first 25 pages, $.50 per page for pages 26-100, and $.25 in excess of 100 pages, with a minimum fee of $10.00 inclusive of copying cost.