South Charlotte Pediatrics, PLLC

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION & RELEASE RECORD

1. Regarding Patient: Medical Record Number:_____

_____
Last Name First Name MI Date of Birth

_____
Street Address

_____
City State Zip Code

2. Information Released From:

_____
Name (Health Care Provider)

_____
Street Address

_____
City State Zip

3. Information Released To:

_____
Name (Hospital, MD, Agency, Etc.)

_____
Street Address

_____
City State Zip

4. This information shall include the following:

Date(s) of service to release: _____

☐ Discharge Summary	☐ Operative Report	☐ Radiology Report
☐ History & Physical	☐ Pathology Report	☐ Emergency Report
☐ Progress/Office Notes	☐ Laboratory/Report	☐ Nursing Notes
☐ Consultation	☐ ECG/EEG/Cardiac Cath	☐ Entire Record

☐ Other (Specify) _____

6. Purpose of Disclosure:

☐ Continuing Treatment	☐ Insurance	☐ Worker's Compensation
☐ Legal Investigation	☐ Disability Determination	☐ Personal

☐ Other (Specify) _____

7. **RESTRICTIONS**: I understand that the recipient of this information may not use or disclose the medical information unless authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

8. I hereby authorize disclosure of the health information for the above-named patient. The authorization is valid for 90 days from the date of the signature. I understand that I may cancel this request with written notification but that it will not have any effect on information released prior to notification of cancellation.

Signature of Patient/Legal Authority: _____ Date:_____

Legal Authority is: ☐ Guardian ☐ Parent of Minor ☐ Attorney in Fact ☐ Next of Kin ☐ Executor of Estate ☐ Other

Patient Is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Documentation Of legal status must be attached.

Health Information Released By:

_____ _____ _____
Name **Title** **Date**