

**Authorization to Release Records  
(Disclose Protected Health Information)**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Account Number:** \_\_\_\_\_ **Daytime Telephone Number:** \_\_\_\_\_

I, \_\_\_\_\_, authorize \_\_\_\_\_  
to release my child's Protected Health Information (PHI) for transfer of care to  
Fayetteville Children's Clinic, P. A., P. O. Box 53127, Fayetteville, NC 28305. I  
have read this authorization and understand the designated information will be  
disclosed only to the recipient(s) outlined below. I specifically authorize any current  
employee or owner of \_\_\_\_\_ to disclose the  
information as outlined. I understand that when the information is used or  
disclosed pursuant to this authorization, it may be subject to re-disclosure by the  
recipient and may no longer be protected health information. I further understand  
that I retain the right to revoke this authorization in writing at a later date.

**Description of the information to be used or disclosed (check all that apply)**

The patient's entire medical record.

Other: \_\_\_\_\_

**Purpose(s) of the information:** \_\_\_\_\_

**I fully understand and accept the terms of this authorization.**

\_\_\_\_\_  
**Patient or Legal Guardian Signature**

\_\_\_\_\_  
**Date**