FAYETTEVILLE
CHILDREN'S CLINIC
P. O. BOX 53127 · FAYETTEVILLE, NC 28305 · 910-484-3121

# Authorization to Release Medical Records

Use this form to have your child's medical records sent to us, or to have us send your child's records to another provider, school, or person. Please complete a separate form for each child.

## PATIENT

**Child's Name** _____ **Date of Birth** _____

**Address** _____ **Phone** _____

## DIRECTION OF RELEASE

☐ Please check one:

☐ **Send records TO Fayetteville Children's Clinic** from the provider named below

☐ **Release records FROM Fayetteville Children's Clinic** to the provider or person named below

**Name of other provider / practice / person** _____ **Phone** _____

**Address** _____ **Fax** _____

## RECORDS TO RELEASE

☐ Complete medical record
☐ Visit / office notes
☐ Lab and test results
☐ Billing records
☐ Immunization record
☐ Growth charts
☐ Specialist / referral notes
☐ Other:

**Other / specific dates or records** _____

**This authorization includes records concerning drug abuse, drug-related conditions, psychological or psychiatric conditions, and/or communicable diseases (including AIDS) only if you initial here:**

## PURPOSE & DURATION

☐ Continuing care ☐ Transfer to a new provider ☐ School / daycare ☐ Personal use ☐ Other:

_____

**This authorization expires on (date or event)** _____ If left blank, it expires one year from the date signed.

I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on it. I understand that information released with my authorization may be re-disclosed by the recipient and may then no longer be protected by federal privacy law. A copy or fax of this authorization is as valid as the original.

_____ _____

**Signature of Parent / Guardian / Patient (if 18 or older)** **Date**

**Relationship to patient** _____ **Printed name** _____

**FOR CLINIC USE**

☐ Identity verified ☐ Released by: _____ **Date** _____