Medical Records Release Form

Authorization of Health or Billing Information

Patient Name:	Patient Address:
Date of Birth:	
	Phone Number:
I give Permission to:	To release information to:
(Name of Person/Facility)	(Name of Person/Facility)
(Address)	(Address)
(City, State, Zip)	(City, State, Zip)
(Phone Number) (Fax Number)	(Phone Number) (Fax Number)

Please Check Information to be Released:

- ☐ Registration Information
- ☐ Insurance Information
- ☐ Medication Records
- ☐ Consultation
- ☐ Specific Treatment Dates: (Please describe below) ____________________ ____________________
- ☐ Entire Medical Record

Describe Reason for Release:

Records to be Released by:

- ☐ Mail (will be mailed to whomever information is being released to)
- ☐ Fax
- ☐ Pick-up in Person
- ☐ Other (describe) ____________________

1. **This is a full release including all drug, alcohol, psychiatric, and sexually transmitted disease information unless otherwise listed here:**____________________
2. By law, my information can't be used or shared without my permission except by ways listed in Novant's Notice of Privacy Practices
3. I can cancel this authorization at any time. I must cancel in writing and address it to the person or organization named above. I can't cancel consent of information already shared as a result of this permission.
4. I do not have to sign this form. Refusal won't change my ability to receive treatment, payment for treatment or benefits.
5. Once information is sent, it may not be protected by law and someone may be able to share my information with others without my permission.
6. I have read, understand, and upon my request, have been given a copy of this form.
7. This is not for Marketing or Research.

Authorization expires 90 days after I sign it, unless a date or event is written here:____________

(Patient/Parent Signature) **(Date)**

Legal Authority of sign for patient: _Guardian __Executor _Attorney __Parent ____Next of Kin

Other (Specify):

Patient is: ____Minor ___Disabled ___Deceased ___Incompetent ___Incapacitated

Notice: Before Greensboro Pediatricians can process this request there is a $20.00 fee per chart for the copying/handling of this information.