Medical Records Release

Date Payment Received: _____
Date Processed: _____
Processed by: _____

Authorization to Disclose Protected Health or Billing Information

***The fee for paper copies/handling is $20 per child and a total of $50 for 3 or more.**
You will be prebilled for your requests.

I give my permission to release the health information of:

Patient Name _____**DOB**_____

Street Address_____

City/State/Zip_____ **Phone**(_____)_____

Release Information From:	**Release Information To:**
Name	**Name**
Address	**Address**
Phone	**Phone**
Fax	**Fax**

Purpose of Release (check all that apply):

- ☐ Insurance
- ☐ Legal
- ☐ Changing Physicians (if so, please indicate the reason) _____
- ☐ Other _____

Please send:

- ☐ Entire Medical Record
- ☐ Growth Charts
- ☐ Psychiatric Notes
- ☐ Immunizations
- ☐ Labs
- ☐ Consultation Notes
- ☐ Specific Dates of Service _____to _____
- ☐ Other: _____

I authorize the disclosure of medical information for the patient named above. I understand that this authorization is voluntary and may be revoked in writing at any time, unless the medical records have already been disclosed. I understand that this authorization includes consent for information that may include substance abuse, mental health, and HIV/AIDS. I understand that this authorization is valid for 12 months from the date signed.

Patient/Parent Name_____ **Date** _____

Patient/Parent Signature_____ **Relationship to Patient**_____

Electronic Signatures: Delivery of this agreement by facsimile, email or other functionally equivalent electronic means of transmission constitutes valid and effective delivery.

Greensboro Pediatricians

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