AUTHORIZATION REQUEST OF MEDICAL RECORDS

Please Mail/Fax
Information to:

Kidz Pediatrics
285 W. Dora Street
Angier, NC 27501-9134
Ph (919) 639-9995 Fax (919) 639-3518

Name of previous clinic/doctor _____ **Nombre de clinica/doctor anterior**

Address _____ Direccion

City/State/Zip code _____ Ciudad/Codigo postal

Tel/Fax _____ Tel/Fax

I give permission for the release of medical record information or disclose protected health information for:

Patient Name _____ Nombre de Paciente

Date of Birth _____ Fecha de Nacimiento
(mm/dd/yy) (Mes/Dia/Año)

Social Security Number _____ Numero Seguro Social

Dates of care from/to _____ Fechas de cuidado medico

Purpose of Disclosure CONTINUED MEDICAL CARE Por la razon de

Check ONE of the following choices:

☐ A complete copy of my medical records **OR**

☐ Specified protected health information necessary for continued treatment: (Check all that apply)

☐ Immunizations ☐ History & Physical Examination ☐ Growth Charts

☐ Labs & X-Ray Reports ☐ Specialist Consultation

☐ Other (specify) _____

I understand the medical information to be disclosed may include phsychological or psychiatric impairment, a communicable disease (such as sexually transmitted disease, HIV/Aids, tuberculosis or hepatitis), mental illness, alcohol or substance abuse. I understand that I may revoke this authorization at any time except to the extent that the information has already been released pursuant to this authorization and before I have revoked my authorization. I have taken the time to read and think about the content of this authorization form and agree with all statements made in this authorization. I understand that treatment will not be conditioned upon my completion of this authorization. This authorization will automatically expire 90 days from date signed.

(Si usted no comprende estos detalles, pida que alguien se los expliquen antes de firmar)

With my signature, I hereby certify and attest that I am the duly authorized personal representative of the above patient and that I have the lawful authority to enter into this authorization on behalf of such patient. I have read the provisions set forth in this authorization and agree that the above listed medical facility may disclose the medical record information requested above of such patient for the purposes set forth herein.

Signed by / Firmado por _____ **Print Name/Nombre en imprenta** _____ **Date/Fecha** _____

Relation to Patient / Parentesco _____ **Tel No.** _____