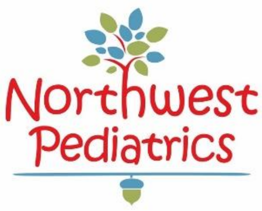



4529 Jessup Grove Road, Greensboro, NC 27410
Phone: 336.605.0190 Fax: 336.605.0930
www.northwestpeds.com


**Authorization to Use/Release/Disclose Health Information**

**Patient Name:** ________________________________________________ **Date of Birth**: _________________________

**Mailing Address**: ______________________________________________ **City:** _________________________________

**State:** ______________ **Zip Code:** _______________ **Patient Phone:** __________________________________

***IF YOU ARE RELOCATING, PLEASE PROVIDE YOUR UPDATED ADDRESS***

**RELEASE FROM**
Name: ___________________________________
Address: _________________________________
Fax#: _____________________________________

**RELEASE TO**
Name: _____________________________________
Address: __________________________________
Fax#: _____________________________________

**I authorize the following information to be sent to the above address: (Check all that apply)**

- ○ Entire Medical Record
- ○ Specific Treatment Dates: _______________ to: _______________
- ○ Reports from other physicians
- ○ Lab, X-Ray, etc. reports
- ○ Other (Please Specify): ________________________________________________________________________

**Reason for transfer/disclosure**: ____________________________________________________________________

**Records to be released by:**

- ○ Mail
- ○ Fax
- ○ CD
- ○ Pick Up in person
- ○ Other _____________________________

***By signing this release, I also understand that the policy of Northwest Pediatrics prohibits a transfer back to the practice from another local pediatrician.***

**Section B: (Must be completed for ALL Authorizations)**
**I understand that:**

- I may revoke this authorization at any time by notifying the Practice in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. I may request or copy the protected health information to be used or disclosed.
- This authorization will expire one year from today's date unless otherwise specified.
- Northwest Pediatrics, Inc. assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization.

**Patient/Parent/Guardian Signature:** ________________________________________ **Date:** ______________________

****Fee for copying medical records is $15.00. As soon as the invoice is paid, your records will be mailed on a CD unless requested on paper. Please allow 10-14 business days for all medical record requests.**

Office use only: Patient Chart #____________ Date Information Disclosed: _______ /______ /_______ Initials: ____________