4529 Jessup Grove Rd.
Greensboro, NC 27410
Phone: 336-605-0190
Fax: 336-605-0930

Authorization to Use/Release/Disclose Health Information

Section A: (Must be completed for all authorizations)

I,_____, understand that Northwest Pediatrics, Inc. is authorized by me to use, release, and/or disclose the Protected Health Information (PHI) as described below. I understand the information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy regulations.

Patient's Name: _____ **Date of Birth:_____**

RELEASE FROM:

Name:_____
Address:_____
_____
_____

RELEASE TO:

Name:_____
Address:_____
_____
_____

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

- ○ Copies of Medical Records for the Period: / / to / / (Mo Day Year) (Mo Day Year)
- ○ Copies of information described below for the Period: / / to / / (Mo Day Year) (Mo Day Year)
- ○ History & Physical Examination
- ○ Reports from other physicians
- ○ Lab, X-Ray, etc. reports
- ○ Other (Please Specify): _____
- ○ The following information should **NOT** be released (Please specify):_____

Reason for transfer/disclosure: _____

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:_____

PLEASE ALLOW 14 BUSINESS DAYS FOR ALL MEDICAL RECORD REQUESTS

Office use only: Patient Chart #_____ Date Information Disclosed: / / Initials:_____