Authorization of Release of Health Information

Kids First Pediatrics, PA

8169 Ardrey Kell Road •Charlotte, NC 28277 •704-542-5540/Fax 704-542-5227

I hereby authorize the use or disclose of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Purpose of Release:

☐ On-going Communication ☐ Copy of Record ☐ Insurance Review
☐ Transferring to Another Practice ☐ Other – Please explain_____

Release from: The facility/practice/individual listed below is authorized to release the requested health information:

Practice Name:
Practice Fax/Phone number:
Records From: (MM/DD/YY) : To: (MM/DD/YY):

Check the Information to be released:

☐All Records ☐Labs/X-Rays ☐Immunization Records ☐Consultation Reports
☐Other_____

Name of Patient whose information is to be released:

Patient Name: Patient Address:	Patient Date of Birth: _____

RELEASE TO: The following information may be released to and used by the following individuals/organizations. A separate authorization must be completed if the individual being released is different from the individuals/organization listed below:

Name/ Relationship	Address	Telephone/Fax #

PATIENT'S RIGHTS AND SIGNATURE:

- I understand that I have a right to revoke this authorization at any time by notifying the above named organization in writing. (I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.)
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to obtain a copy of the information to be used or disclosed per the Notice of Privacy Practices available and given out at Kids First Pediatrics.
- This authorization will expire when the information from the event/purpose noted above is released to the recipient named in this document. If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

PRINT NAME (Patient/Authorized Representative):
SIGNATURE:
DATE: **If Authorized Representative, please indicate relationship to patient:** **☐Parent ☐Guardian ☐Power of Attorney**

MINOR'S SIGNATURE: Please note if the information is relating to the treatment of pregnancy, drug and/or alcohol abuse, venereal disease or emotional disturbance for a patient under the age of 18, the patient must also sign this authorization.

NAME OF MINOR:	SIGNATURE OF MINOR: