the ChildHealth Center, P.A.

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1455 25th Avenue Drive, NE, Hickory, NC 28601 — Phone: (828) 322-4453 — Fax: (828) 324-9295

Authorization For Release of Medical Information

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

Address: _____

Home Phone: _____ Cell Phone: _____

I hereby authorize and request The ChildHealth Center, P.A.
to release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone#/Fax# (include area code)

Medical Information to be released: ___All records concerning previous history, evaluation and treatment (including immunization record)
___Hospital records
___Other_____

Purpose for this request: (Check one)___Personal Copy ___Over age 21 ___Insurance Change ___Relocation ___Referral to Specialist
___Dissatisfaction (Reason)_____
___Other_____

I do hereby consent and authorize you to release copies of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information, and any information relating to HIV testing, AIDS, and any AIDS related syndromes. It also includes any information concerning cancer, cancer testing and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as the original release. Please send copies of all requested information as soon as possible to the address listed above.

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is: $.**75 per page for the first 25 pages, $.50 per page for pages 26-100, and each additional page will be billed at $.25 per page.** *I also understand that this process can take anywhere from 7-10 business days.*

_____ _____
Signature of Patient or Legal Guardian Date*

_____ _____
Print Name of Patient or Legal Guardian Relationship to the patient

*Release requests expire 90 days from signature date.

FOR INTERNAL PURPOSES ONLY: Name & Title of Person Releasing Records_____
Method of Transfer: ___Mailed on (date) _____
___Faxed to (number) _____ on (date) _____
___Picked up by (name) _____ on (date) _____
___Release faxed on (date) _____