Triangle Pediatric Center, P.A.

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Release records to: _____

Adress:_____

Phone:_____ Fax: _____

Email:_____

Information to be released by Triangle Pediatric Center, P.A.

The type of information to be used or disclosed is as follows (check all that applies):

- **Basic Records: $5.00 fee per family (No charge if doctor to doctor)**
  (Most recent physical exam, growth chart, vaccines records, medication list, problem list, lab reports & ER reports)
- **All Records: $25.00 fee per family (No charge if doctor to doctor)**
  (All physical exams, office visits, summary of vaccines, growth charts, medication list, and problem list, referral reports, ER/UC reports and lab reports.)
- **Records from previous providers: $10.00 fee per family**
- **Other:** _____

Reason for Release: ☐ Insurance Change ☐ Moving ☐ Aged Out ☐ Other:_____

By signing you agree to the following: The information in my health records may include information relating to sexually transmitted disease, behavior/mental health services, or alcohol/drug related issues. Triangle Pediatric Center, P.A. assumes no responsibility for the use or misuse by others of the health information disclosed under this authorization. I release Triangle Pediatric Center, P.A. from all legal liability that may arise from this authorization. This authorization will expire on the date of the release by the above organization. I revoke the authorization, or 6 months (180 days) from the date of signature indicated below, or whichever occurs first.

_____ _____ ____/____/____

Signature of Patient/Parent/Legal Guardian — Relationship to Patient — Date

(Patient signature only if they are 18yrs or older)

Patient Information

1._____ DOB:___/____/____
(Patient Name)

2._____ DOB:___/____/____
(Patient Name)

3._____ DOB:___/____/____
(Patient Name)

4._____ DOB:___/____/____
(Patient Name)