Triangle Pediatric Center, P.A.

105 Ridgeview Drive
Cary, NC 27511
Phone: (919)467-5543 Fax: (919)469-2391
www.tripeds.com or Email: medicalrecords@tripeds.com

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Request records from: _____
Address: _____
Phone: _____ Fax: _____
Email: _____

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

- All Records (including any physical exams/office visits, summary of vaccines, growth measurements, medication list, and problem list.)
- Records only from (date): _____ to (date): _____
- Other: _____

To be Released to: Triangle Pediatric Center, P.A.
105 Ridgeview Drive
Cary, NC 27511

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)

5. _____ DOB: ___/___/___
(Patient Name)