Medical Record Release Authorization NO DOUBLE SIDED COPIES

Patient Name________________________________ DOB_______________

Patient Name________________________________ DOB_______________

Patient Name________________________________ DOB_______________

Patient Name________________________________ DOB_______________

Patient Name________________________________ DOB_______________

A) I hereby authorize records FROM:

Name Triangle Pediatric Center, P.A.

Address 105 Ridge View Dr

City/State/Zip Cary, NC 27511

Phone# 919.467.5543 Fax# 919.469.2391

B) To be released TO:

Name____

Address____________________________________

City/State/Zip_______________________________________

Email____________________________________

Phone#________________FAX#_________________________

C) For the purpose of:

_____Litigation

_____Insurance

_____Self/Personal Copy

_____Continuity of Care

_____Disability

_____Aging Out

_____Other

_____Transfer of Care/Moving

Date Range__________________to________________

☐ Physician Office Notes

☐ Immunizations

☐ Operative/Procedure Reports

☐ Other _____________

☐ Cardiology/Radiology

☐ Lab/Path Reports

☐ Minimum Necessary

☐ **All Records**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the 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 have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

___________________________ ____***Subject to Fees**

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: ___________________________

(Expiration date of authorization)

***PLEASE READ** Fee Information*:* **Triangle Pediatrics** reserves the right to charge the medical record state fee structure as set forth in the state statue. Copy charges plus postage will be invoiced to you with all necessary directions to receive your records. By signing this authorization, you are agreeing to pay Triangle Pediatric Center, P.A. for your records. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy.

medicalrecords@tripeds.com