Thomasville-Archdale-Trinity Pediatrics, PLLC

☐Thomasville Pediatrics
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Thomasville, NC 27360
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☐Archdale-Trinity Pediatrics
210 School Road
Trinity, NC 27370
T(336)861-2348 F(336)861-2353

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

______________________________ (Responsible Party)

______________________________ Patient Name

______________________________ (Street Address)

______________________________ Birth Date (Month/Day/Year)

______________________________ (City, State, Zip Code)

______________________________ Social Security Number

______________________________ Phone (Home)

At the request of the individual, I ______________________________, do hereby authorize

____
(Name of Facility)

______________________________ ______________________________ to release:
(Address of Facility) (Telephone Number)

INFORMATION TO BE RELEASED:

_____ Entire Medical Record

_____ Specific Condition

_____ Other

_____ Specific date of service (dates) ______________

_____ Specific Medications ______________

_____ I do _____ I do NOT authorize release of information related to AIDS(Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

____
Practice/Physician/Agency/Facility/Person

____
Street Address

____
City, State, Zip

_____ *Physician awaiting records*

PURPOSE OF DISCLOSURE:
___ REFERRAL TO SPECIALIST
___ INSURANCE
___ CHANGE OF DOCTOR
___ LEGAL INVESTIGATION
___ PERSONAL
___ DISABILITY DETERMINATION
___ CONTINUING CARE
___ WORKERS COMP
___ OTHER (SPECIFY) ______________________________

Please provide current telephone number in the event we need to contact you: ______________________________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to this notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign authorization.

NOTE: There will be a charge for any personal copy or the permanent transfer of your records. Health Port Solutions has been contracted to provide this service and will invoice you directly.

______________________________ ______________________________
Patient and/or legal custodian signature: Date: