



Authorization to Use / Release/ Disclose Health Information

*PLEASE MAIL ALL RECORDS TO OUR OFFICE AT , 2710 HENRY STREET STE 100-B GREENSBORO, NC 27405
IF LESS THAN 25 PAGES YOU MAY FAX TO THE MEDICAL RECORDS DEPARTMENT AT 336-617-3150.

Patients Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____

Release Records From:

NOTE: Some providers such as Duke prefer their form to be completed and will not accept our form. Please obtain a form from their office.

Name: _____ Phone: _____ Fax: _____
Address: _____ Street _____ City _____ State _____ Zip _____

Release Records To:

Name: _____ Phone: _____ Fax: _____
Address: _____ Street _____ City _____ State _____ Zip _____

How would I like the records to be released? Mailed to the "Release To" address Pick up by: _____

Fax to Provider: _____ Physician Name/ Health Care Facility _____ Fax Number _____ Phone Number _____

Through oral communication with healthcare providers regarding treatment, care or payment.

Purpose: Continuation of Care Insurance Legal Personal* Other (specify) _____

Treatment Date(s): Treatment dates from _____ to _____ (Please be specific) OR ALL Treatment Dates

Information to be Released:

- I would like to review onsite, the protected health information for the above dates.
 I would like copies of specific reports for the treatment dates listed above (check reports below).

Grid of checkboxes for record types: ENTIRE RECORD, Summary Information, Radiology Reports, Laboratory Reports, ED Record, Discharge Summary, Pathology Reports, Immunization Records, Operative Reports, PT/OT Notes, History & Physical, Other.

BE SURE TO INCLUDE LAST WELL EXAM, IMMUNIZATIO RECORD, GROWTH CHART, PROBLEM LIST, MEDICATION LIST, NEWBORN SCREENING AND LEAD RESULTS.
Understand That:

The information to be released may include a diagnosis or reference to the following conditions: sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV), psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment, and treatment for alcohol and/or drug abuse.

- Without my express revocation, this Authorization will automatically expire one year from the date signed below, unless I request an expiration date less than one year.
I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation.
Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Signature: My signature is required to validate this Authorization to release medical information. If I do not sign this authorization, Greensboro Children's Clinic, PA will still provide treatment and seek payment for services provided. According to the North Carolina General Statues, Health Information Management may charge for copies of medical records.

*I understand and agree that I am financially responsible for the following fees associated with my request: Copying charges, including the cost of supplies, 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 \$.25 in excess of 100 pages, with a minimum fee of \$10.00 inclusive of copying cost.

Signature of Patient/ Guardian/ Personal Representative _____ Date _____
 Parent Self Administrator
 Health Care Power of Attorney Next of Kin
 Legal Guardian (legal paperwork must accompany this form)
 Other _____

Witness (not necessary for form to be valid) Requested Expiration Date _____
Please note that some facilities prefer to use their release form and will not accept ours. To avoid a delay in processing please verify with your previous provider.