Concord Children's Clinic
1040 Vinehaven Drive NE, Concord NC 28025
Phone: 704-784-1010 Fax: 704-784-1013
www.ConcordChildrensClinic.com

RELEASE OF MEDICAL INFORMATION

Patient Name

_____

(First) (Middle Initial) (Last)

_____

(Date of Birth) (Social Security Number) (Phone Number)

_____

(Mailing Address)

At the request of the above individual, I _____, authorize the release of the following records or summary or narrative of my protected health information from and to the entities stated below.

☐	Discharge Summary	☐	ECG / EEG /Cardic Cath	☐	Radiology Reports
☐	Physical & History	☐	Pathology Reports	☐	ER Reports
☐	Immunization Record	☐	Lab Reports	☐	Operative Reports
☐	Progress Notes	☐	Other		

I DO	I DO NOT	*(check one box)*
☐	☐	Authorize release of information related to AIDS and/or HIV infection, Psychiatric Care and/or Psychological Assessment, and treatment of Alcohol and/or Drug use

Information Released From:

_____

(Name of the Facility/Company/Person)

_____

Address

_____

Phone Number

_____

Fax Number

Information Released To:

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Concord, NC 28025
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