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:

_____

(Name of the Facility/Company/Person)

_____

Address

_____

Phone Number

_____

Fax Number

Purpose:

☐ Change Physician ☐ Insurance ☐ Referral to Specialist

☐ Legal Investigation ☐ Disability Determination ☐ Personal ☐ Other

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of the signature. I understand that I may cancel the request with written notification but that it will not effect any other information released prior to notification of cancellation. I understand that the information disclosed may be re-disclosed by the individual, group, or facility receiving it and may no longer be protected under federal privacy regulations. I also understand that the medical provider receiving this authorization cannot condition my treatment on whether or not I choose to sign it.

_____ _____ _____

Name of Guardian Relationship to Patient Date