2035 Valleygate Drive – Suite 101
Fayetteville, North Carolina 28304
Phone (910) 484-8009
Fax (910) 484-2205

Authorization for Release of Health Records

Regarding Patient – (Complete in Full)

____
Last First MI

____
Street Address

____
City State ZIP

____
Date of Birth Social Security Number

Records Released To:

____
Name of Clinic / Physician

____
Street Address/PO Box

____
City State ZIP

____
Phone

____
Fax

Records Released From:

____
Name of Clinic / Physician

____
Street Address/PO Box

____
City State ZIP

____
Phone

____
Fax

Information to Be Released –

- ☐ Immunization Records
- ☐ Flow Sheets
- ☐ Other ___________________________

The purpose of this disclosure –

- ☐ Further Health Care (Continuity of Care)
- ☐ Personal
- ☐ Other ___________________________

I authorize release of my child's health records in accordance with the specifications listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

I understand the following:

- The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
- That I may revoke this authorization at any time by giving written notice to the physician of my desire to do so.
- That I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose of my health information.
- This authorization will expire on ____.

(Give at least 45 Days from today's date.)

____ ______________________
Signature of Parent or Legal Guardian Date

THIS DOCUMENT MUST HAVE A SIGNATURE. AFTER COMPLETING, THE FORM MUST BE FAXED, OR YOU MAY SCAN AND EMAIL TO MEDREC@CROSSCREEKPEDIATRICS.COM. IF YOUR CHILD IS TRANSFERRING TO OUR GROUP THIS FORM IS REQUIRED.