

BLUE RIDGE PEDIATRICS, LLP
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Fax (919) 571-0825

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Phone (919) 226-0662
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Fees for Copies of Health Information

In order to better serve you, our facility contracts with HealthPort to process your request for copies of medical records.

There may be a charge for reproduction of records unless you are referred by our facility to another provider.

Effective January 1, 2008, fees will be the following:

\$.75 per page for 1-25 pages

\$.50 per page for 26-100 pages

\$.25 per page for 100+pages

Plus actual postage

All invoices will be billed by HealthPort. Upon receipt of your invoice, simply include the bottom portion of your invoice along with your check for the balance due. Your invoice will include a phone number if you choose to pay by credit card or you may go to www.HealthPortPay.com to pay your invoice. If you have any further questions, feel free to contact HealthPort customer services at 1-800-367-1500.

Blue Ridge Pediatrics

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Records Release Authorization

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Release From:

Release To:

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

I authorize the following information to be sent to the above address:

____ Copies of all medical records for the period: ____/____/____ to ____/____/____

____ Other (please specify): _____

Purpose of releasing this information: _____

____ Changing Insurance ____ Moving ____ Dissatisfaction with Doctor/Staff

____ Other (Please specify above)

***All medical records requests take 7 to 10 business days to process. There is a fee based on the number of pages, in accordance with North Carolina law.**

My signature below indicates that I understand what information will be released and the need for that information. I further understand that the information to be released may include information regarding drug and alcohol abuse or AIDS/HIV. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in the 42 Code of Federal Regulations Part 2. This consent will expire on _____, not more than 365 days from the date of signature.

I understand that I may revoke this authorization in writing at any time. This revocation will only be effective from the date it is received in this office and will not apply retroactively.

Signature of legally responsible person

Relationship

Date