Blue Ridge Pediatrics, LLP
Records Release Authorization

Parent/Guardian Name: ____

Parent/Guardian Address and Phone:_______________________________________

____

The complete history of records in your possession, concerning my illness and/or treatment during the period from ________to________ for:

____
Patient's Name Date of Birth

____
Patient's Name Date of Birth

Records Released To:

Name:______________________________

Address:____________________________

____

Records Released From:

Name:___________________________

Address:__________________________

____

The purpose of releasing this information:___________________________________

____Changing insurance ____Moving ____Dissatisfaction with Doctor/Staff

____Other (Please specify above)

***All medical records take 7 to 10 business days to process. There is a fee based on 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 consent in writing at any time, but that it will remain valid to the extent released based on this consent has already occurred. This consent will expire 365 days from date of signature; therefore, there will be an additional charge for all other consents of release.

____
Signature of client/legally responsible person

____
Relationship

____
Date