AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Eastern Carolina Pediatrics, P.A. 1702 Medical Park Dr. Wilson, NC 27895

Telephone: 252-243-7944 Fax: 252-243-6097

*****THIS FORM MUST BE COMPLETED IN FULL*****

Patient Information:

Last Name _____ First Name _____

Birth date ___/___/___ Telephone (___) ____ - _____ Type of Insurance _____

Current Address _____

City _____ State _____ Zip Code _____

(choose one of the following)

____ ECP to receive records from **OR** _____ ECP to release records to

Name / Facility _____

Address _____

City _____ State _____ Zip Code_____

Telephone # (___) ____ - _____ Fax# (___) ____ - ____ (if not available, request will be mailed)

Covering the periods of healthcare from (date) _____ **to** (date)_____

_____ Limit to last 3 years of visits at practice including last well child check and growth charts

Information to be disclosed:

_____ Office / Progress Notes _____ Labs _____ X-ray Reports ____ Immunizations (All)

_____Other (please specify) _____

Purpose of disclosure:

_____ Transferring Care ____ Attorney/Legal ____ Insurance ____ Personal Use ____ Continuing Care

_____ Other (please specify) _____

I understand the medical information to be disclosed may include psychological or psychiatric impairment, a communicable disease (such as transmitted disease, HIV/Aids, tuberculosis or hepatitis), mental illness, alcohol or substance abuse. I understand that if the person or organization receiving this information is not a healthcare provider, health organization or health plan covered by federal privacy regulations, then this information may be re-disclosed and no longer protected by these regulations. I understand that I may revoke this authorization at any time except to the extent that action has already been taken. I have taken the time to read and think about the content of this authorization form and agree with statements made in this authorization. I understand a reasonable fee may be charge for duplication of the Health Information. I understand that treatment will not be conditioned upon my completion of this authorization. This authorization will automatically expire 6 months from date of signature.

Authorized Signature _____ **Date** _____

Print Name _____

Relationship to Patient _____