

Chapel Hill Pediatrics & Adolescents, P.A.

Phone: 919-942-4173 Fax: 919-933-3473

Authorization for Release of Medical Information

(Patient Name) (Birth Date)

(Address) Phone (Work)

(City) (State) (Zip) Phone (Home)

I, _____ do hereby authorize _____
(Previous Pediatric Practice Name)

_____ and/or _____
(Prev. Practice's Phone #) (Prev. Practice's Fax #)

to release all medical records pertaining to the care and treatment received from _____ to _____

I do / I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.
(Circle One)

To:
(New Pediatric Practice)

Chapel Hill Pediatrics and Adolescents, PA
(Location)

205 Sage Road, Suite 100
(Address)

Chapel Hill **NC** **27514**
(City) (State) (Zip)

Is this a permanent transfer? _____ Reason for request: _____

Signature of Patient (if 12 yrs. old or older) (Only Valid for 90 days) Date

Signature of Parent or Legal Guardian (if patient is under 18 yrs. old) Date

Only information pertaining to care received at Chapel Hill Pediatrics & Adolescents will be forwarded. Questions may be directed to Debbie Shore, Office Manager at 919-942-4173 ext. 197.