Medical Information Release

BURLINGTON PEDIATRICS P.A.
530 West Webb Avenue – Burlington, NC 27217
Telephone: (336) 228-8316 – Facsimile: (336) 227-9750

Pediatric and Adolescent Medicine
Consent for Release of Information

Patient’s Name: ______________________________

Patient’s Phone Number: ______________________________

Patient’s Address: ______________________________

Patient’s Date of Birth: ______________________________

I do hereby consent and authorize: ______________________________
(Name of doctor, clinic, or hospital releasing information)

____

____
(Address)

Phone#: ______________________ Fax#: ______________________

To release to: ______________________________
(Name of doctor, clinic, or hospital receiving information)

____

____
(Address)

Phone#: ______________________ Fax#: ______________________

Reason for Transfer: ______________________________

Copies of my medical information, including current and previous medical records for other practices and practitioners, hospital, and any information relating to HIV testing, Alcohol or any mental conditions, AIDS and any AIDS Related Syndromes. I agree that a copy of this release or a fax of this release shall be as valid as this original release.

Please send copies of all requested information as soon as possible.
Send all records
Send records from (Date)______________ to (Date) ________________

Send records in regards to ______________________________

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN AND THAT IT WILL EXPIRE AUTOMATICALLY NINETY (90) DAYS FROM THE DATE INDICATED BELOW.

______________________________ ______________________
Signature of Patient Date

______________________________ ______________________
Witnes Date

______________________________ ______________________
Signature of Patient's legal Representative (if applicable) Date