Release of Medical Information

Burlington Pediatrics
530 West Webb Avenue
Burlington, NC 27217
336.228.8316
336.227.9750 (FAX)

Burlington Pediatrics West
3804 South Church Street
Burlington, NC 27215
336.524.0304
336.584.4387 (FAX)

Mebane Pediatrics
3940 Arrowhead Blvd, Ste 270
Mebane, NC 27302
919.563.0202
919.563.0242 (FAX)

Patients Name:_____DOB:_____Phone:_____

Address:_____Insurance:_____

I am transferring my records: □ OUT OF BURLINGTON/MEBANE PEDS □ INTO BURLINGTON/ MEBANE PEDS □ COORDINATION OF CARE

If transferring out of our practice we will treat for emergencies only for the next 30 days from today's date. If you need assistance in locating a physician, please contact the Physician Referral Service through Cone Health at: 1-336-832-8000.

Information Released From: **NOTE: Some providers such as Duke prefer their form to be completed and will not accept our form. Please obtain a form from their office.**

Name:_____Phone:_____Fax:_____

Address:_____
Street City State Zip

Information Released To:

Name:_____Phone:_____Fax:_____

Address:_____
Street City State Zip

How would I like the records to be released? □ Mailed to the "Release To" address □ Fax to Provider □ Pick up by:_____
□ Through oral communication with healthcare providers regarding treatment, care or payment.
Purpose: □ Continuation of Care □ Change of Doctor □ Insurance □ Legal □ Referral to Specialist □ Disability □ Personal* □ Other_____
Treatment Date(s): Treatment dates from _____ to _____ OR □ ALL Treatment Dates
Information to be Released:
□ I would like to review onsite, the protected health information for the above dates.
□ I would like copies of specific reports for the treatment dates listed above (check reports below).

□ ENTIRE RECORD	□ Radiology Reports	□ Pathology Reports
□ History & Physical	□ Laboratory Reports	□ Operative Reports
□ Immunization Records	□ Summary Information (Discharge	□ ED Record
□ Last Well Exam, Immunization Record,	Summary, Operative Notes/ Procedure	□ Discharge Summary
Medication List, Problem List, Growth Chart,	Notes, Radiology, Pathology, Laboratory,	□ PT/OT Notes
Labs	EKG, ED Notes, Clinic Visits, Consults)	□ Other_____

□ **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.

Understand That:
● Without my express revocation, this Authorization will automatically expire one year from the date signed below, unless I request an expiration date less than one year.
● I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation.
● Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Signature: My signature is required to validate this Authorization to release medical information. If I do not sign this authorization, Burlington/ Mebane Pediatrics will still provide treatment and seek payment for services provided. According to the North Carolina General Statues, Health Information Management may charge for copies of medical records.

*I understand and agree that I am financially responsible for the following fees associated with my request: Copying charges, including the cost of supplies, labor, and postage related to the production of my information. I understand that the charge for this service is $.75 per page for the first 25 pages, $.50 per page for pages 26-100, and $.25 in excess of 100 pages, with a minimum fee of $10.00 inclusive of copying cost.

_____ _____
Signature of Patient/ Guardian/ Personal Representative **Date**
□ Check if this is an electronic signature

□ Parent □ Self □ Administrator
□ Health Care Power of Attorney □ Next of Kin
□ Legal Guardian (legal paperwork must accompany this form)
□ Other_____

_____ _____
Witness (not necessary for form to be valid) Requested Expiration Date

Please note that some facilities prefer to use their release form and will not accept ours. To avoid a delay in processing please verify with your previous provider.