Christina Flannelly, MD
Michele McMillan, MD
Nirali Dubal, MD, MPH
Christopher Wilson, MD
Stephen Ray Coleman, MD

8300 Health Park, Suite 213
Raleigh, NC 27615
919-896-7066
FAX 919-896-7067
HealthParkPeds@rdmgpa.com

Authorization for Release of Patient Health Information

Patient Information:

Patient Name: ____ Patient Date of Birth:_________________

Address: ____

City/State/ZIP: ______________________________________ Telephone:______________________________

I hereby authorize the protected health information regarding the above-named person to be exchanged between:

From:
Person/Institution: __________________________
Address: ________________________________
City:___________________________________
State/ZIP:_______________________________
Phone/Fax: ______________________________

To:
Person/Institution: __________________________
Address: ________________________________
City:___________________________________
State/ZIP:_______________________________
Phone/Fax: ______________________________

I authorize the release of information covering the period(s) of healthcare from:

Date(s):____________________________________ to date(s)_____________________________________

The type of information to be used or disclosed is as follows:

- ☐ Medical Summary (This includes: Immunizations, Last Physical, Growth Charts and Problem List). **Nothing prior to 2008*
- ☐ Complete Records – *HealthPark Pediatrics charges a $15 fee for complete records unless you are over the age of 18 or under the age of 1.*
- ☐ Verbal Only (please specify):____
- ☐ Records associated with a referral
- ☐ Letter, needing the following information:____
- ☐ Other, please be specific:____

The following highly confidential items must be circled to be included in the use or disclosure of other health information:

Genetic testing information/records
Information about child abuse or neglect
HIV/AIDS related health information/records
Behavioral or mental health information (ADD/ADHD included)

Information about sexually transmitted diseases
Pregnancy
Birth Control
Drug/Alcohol Diagnosis, treatment, and/or referral information

The information for which I am authorizing disclosure will be used for the following purpose:

Personal Use
Sharing with other healthcare providers (Referral/Specialist)
Transfer to another practice

Legal
Other:__________________________

This authorization will expire:

Date: ____

If not otherwise specified, this release will expire within 30 days of the date of signature.

Authorization for Release of Patient Health Information

Patient Name: ____ Patient Date of Birth:_____________________

Unless revoked, this authorization will expire 30 days from the date of signature on the authorization or from the date noted above. *For mental health purposes this authorization will expire one year from the date of signature.*

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

I understand that once HealthPark Pediatrics discloses my health information to the recipient, HealthPark Pediatrics cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and North Carolina law governing the use and disclosure of my health information.

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to HealthPark Pediatrics Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that HealthPark Pediatrics may, directly or indirectly, receive remuneration from a third party in connection with the use and disclosure of my health information.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorization HealthPark Pediatrics to use or disclose my health information in the manner described above.

____ ________________________________

Printed Name of Patient 18 or over or Legal Guardian **Relationship**

____ ________________________________

Signature of Patient 18 or over or Legal Guardian **Date**