MEDICAL RECORDS RELEASE

Kids Rule Pediatrics, PA
3604 Medical Park Court
Morehead City, NC 28557
252-240-KIDS (5437)
FAX 252-240-3084
www.240kids.com

(Print patient full name) _____ (Birth Date Mo/Day/Year) _____

(Street Address) _____ (Social Security Number) _____

(City, State, Zip) _____ (Phone Number & Cell Number) _____

REASON FOR TRANSFER:

_____

_____

INFORMATION RELEASED TO: Kids Rule Pediatrics, PA
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Morehead City, NC 28557
252-240-KIDS (5437)
FAX 252-240-3084
www.240kids.com

PHONE — 252-240-5437 **FAX 252-240-3084**

AT THE REQUEST OF THE INDIVIDUAL, I _____,
(patient's parent or guardian name)

DO HEREBY AUTHORIZE _____ **TO RELEASE:**
(Facility/Phone number)

Dates of _____

____ Discharge summary ____ Pathology reports ____ Emergency Reports ____ History & Physical
____ Laboratory reports ____ Progress Notes ____ Radiology Reports ____ Other _____
____ Operative Notes ____ ECG/EEG/Cardiac Cath

____ **I DO** ____ **I DO NOT** **authorize release of information related to any of the following:**
-ADHD and/or psychological assessment, -Psychiatric care, treatment for alcohol and/or Drug abuse
-AIDS(Acquired Immunodeficiency Syndrome)- HIV(Human Immunodeficiency Virus)Infection

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____ _____
(Signature of Individual or Guardian or Personal Representative of patient's estate) (Date) (Phone #'s)

NOTE: THERE WILL BE A 'CHARGE' FOR A PERSONAL COPY AND/OR THE PERMANENT TRANSFER OF YOUR RECORDS. 'HEALTHPORT' IS CONTRACTED TO PROVIDE THIS SERVICE AND WILL BILL YOU DIRECTLY.

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE___LAB___EKG___DS___IMMUNE___EEG___OP___XRAY___PATH___HP___OTHER_____NUMBER PGS___

ROI SPECIALIST_____ DATE_____

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INFORMATION RELEASED TO: _____
(Name of Office/Company/Facility/Person)

_____
(Street Address)

_____ **FAX** _____
(City, State, Zip)

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