For office use only
❑Mailed_____
❑Faxed_____
❑Picked up_____
❑Emailed_____

64 Peachtree Rd, Suite 100 – Asheville, NC 28803 – Phone 828-277-3000 – Fax 828-210-3885

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please read ALL information and instructions before completing and signing the authorization form

Patient's Name (please print)_____ Birth date_____
Mailing Address _____City _____State____Zip_____

Name of Person Requesting Information/Phone number_____

INFORMATION TO BE RELEASED *BY:*	INFORMATION TO BE RELEASED TO:
❑ ABC Pediatrics ❑ Other facility (please list name, address, phone and fax)	❑ ABC Pediatrics ❑Other facility (please list name, address, phone and fax)

TYPE OF MEDICAL INFORMATION REQUESTED:

❑ Complete chart-(this includes **last 3 yrs** office notes and immunizations) ❑ Last physical & Immunizations

❑ Clinical Summary ❑ Behavioral/Mental Health ❑ Labs ❑Daycare Form ❑Sports Form

❑ Specific date(s)_____

REASON FOR REQUEST: ❑ Daycare/School ❑ Referral ❑ Transfer of care to another physician

❑ Insurance ❑ Legal review ❑ Sports

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (lily). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below.

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, anytime.

Patient Signature _____ Date_____