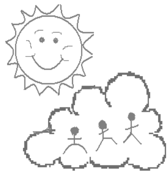

Carolina Pediatric Group, P.A.

538 Sandhurst Dr.
Fayetteville, NC 28304
Phone: (910) 321-7337

Holly M. Richter, MD

Sandy Strickland, NP

Date: ____________________
Patient Name: ____________________________
Address: __________________________________
____

DOB: ______________________
Phone: ____________________
Chart #: ___________________

☐ I authorize Carolina Pediatric Group to **obtain information from:**

____
Name of Provider or Facility

____
Address

____
City, State, Zip Code

____
Phone #/Fax # (including area code)

☐ I authorize Carolina Pediatric Group to **release information to:**

____
Name of Provider or Facility

____
Address

____
City, State, Zip Code

____
Phone #/Fax # (including area code)

Purpose of Disclosure: __ Transfer of Care __ Legal __ Specialist __ Other:____________

INFORMATION TO BE DISCLOSED

__ All Health Care information **including** immunization records, growth charts, lab and x-ray reports, etc.
If you are transferring from Carolina Pediatric Group, P.A. there will be a minimal charge of $15.00 per child.

__ Other: _______________________ __ Specific time frame:________________

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at on this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- The information may contain testing or treatment relating to sexually transmitted diseases.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

☐ I understand that this authorization remains in effect for 1 year from the date of my signature below and that a photocopy of this authorization is granted the same authority as the original.

OR

☐ I understand that this authorization is valid until ____/___/______ or until the following event ____.

_________________________________ ___/___/______ ____________________
(Patient/Legal Representative) (Date) Relationship to Patient

_________________________________ ___/___/______
(Witness) (Date)