HENDERSONVILLE PEDIATRICS, P.A.
157 Medical Park Drive • Brevard, NC 28712
Phone (828) 693-3296 • Fax (828) 696-3530

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION
OUTGOING RECORDS

1. PATIENT INFORMATION:

Last Name | First Name | Middle Initial | Date of Birth | Social Security Number

Street Address | City | State | Zip Code | Phone

2. INFORMATION RELEASED TO:

Last Name (Facility, Agency, etc.)

Street Address

City | State | Zip Code

Phone and FAX Numbers (Including Area Code

3. INFORMATION TO BE RELEASED FROM:

Hendersonville Pediatrics
157 Medical Park Drive
Building 3
Brevard, NC 28712
Phone (828) 693-3296
Fax (828) 696-3530

4. THIS INFORMATION SHOULD INCLUDE THE FOLLOWING: *(Please initial each item to be released.)*

☐ Clinic Notes/Office Visits ☐ Immunizations ☐ Past Medical History
☐ In Office Laboratory Reports ☐ Growth Chart ☐ Other _____

5. NOTICE:

This authorization is for FULL DISCLOSURE OF ALL RECORDS, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of health care personnel, dates of visits, charges, and any other information that may be related to drug, alcohol, psychiatric conditions, an/or sexually transmitted disease, including HIV/AIDS information. Such records will be disclosed unless specified information to exclude is listed below.

EXCLUSIONS: _____

6. PURPOSE OF DISCLOSURE:

☐ Continuing Treatment ☐ Insurance ☐ Personal Use ☐ Other *(specify)* _____

7. REDISCLOSURE:

I understand the recipient of this information may not use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

8. AUTHORIZATION:

I hereby authorized disclosure of the health information for the above named patient. This authorization is valid for 90 days from the date of signature. I understand I may cancel this request with written notification but that it will not have any effect on information released prior to this notification.

SIGNATURE OF PATIENT/
LEGAL AUTHORITY _____ DATE _____

SIGNATURE OF WITNESS _____ DATE _____

HEALTH INFORMATION REQUESTED
ABOVE WAS RELEASED BY _____ DATE _____

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