HENDERSONVILLE PEDIATRICS, P.A.
600 Beverly-Hanks Centre, Hendersonville, NC 28792
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HENDERSONVILLE PEDIATRICS, P.A.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
INCOMING RECORDS

Please fill out the following and return to the office using the correct address from above.

I hereby request that _____ *(name of practice)* copy and release the copies of medical records as specified below for my child/children or myself to Hendersonville Pediatrics.

NAME OF PATIENT	DATE OF BIRTH	NAME OF PATIENT	DATE OF BIRTH

☐ I request immunization records only be sent to Hendersonville Pediatrics.

☐ I request and authorize _____ *(name of practice)* to release all medical information and records concerning the history, treatment, examination, hospitalizations, and any other information that may be related to drug, alcohol, psychiatric conditions, an/or sexually transmitted disease, including HIV/AIDS information from _____ *(date)* to: please fill in information below. Such records will be disclosed unless specified information to exclude is listed below.

Exclusions: _____

Your current Information	Information for Where Records Should Be Released From:
Name:	Name of Practice:
Street Address:	Street Address:
City, State, Zip:	City, State, Zip:
Phone Number:	Phone Number:

Reason for the record transfer: *(please mark and fill in requested information.)*

☐ Moving out of state: *(please provide new information and the date they become effective in case we need to contact you.)*

My new address and phone number take effect on _____ Phone _____

Address _____

City _____ State _____ Zip _____

☐ Changing to another practice due to *(please box for reason):*

☐ Insurance change ☐ Location ☐ Age of Patient ☐ Size of Practice

☐ Other *(please specify)* _____

- I understand that the release or transfer of the information specified above to any person or entity not specified above is prohibited.
- I understand that I may revoke this consent at any time except to the extent that action has already been taken and that it expires 90 days from the date indicated below.
- I understand that it take approximately 10 working days to complete this request.

Signature _____ Date _____

Relationship to Patient _____ *(Patient must sign if 18 years of age or older.)*