



**HENDERSONVILLE
PEDIATRICS, P.A.**

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