



**HENDERSONVILLE PEDIATRICS, P.A.**  
 157 Medical Park Drive • Brevard, NC 28712  
 Phone (828) 884-3440 • Fax (828) 884-5643

**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.*)