Oberlin Road Pediatrics

1321 Oberlin Road, Suite A
Raleigh NC 27608
Phone 919.828.4747 - Fax 919 828 6765

Authorization to Use/Release/Disclose Health Information

I authorize the use, disclosure, and release of my protected health information (PHI) as described in this Authorization. I understand that information disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

Patient Name: _____ Date of Birth: _____/_____/_____

Organizations/Persons Providing the Information:	*Organizations/Persons Receiving the Information*
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone No. _____ Fax No._____	Phone No. _____ Fax No._____

Delivery Method (Select One):

□ Complete Electronic Medical Record (EMR) Copy via Encrypted Email-
By selecting "Electronic Medical Record (EMR) Copy via Encrypted Email," I authorize Oberlin Road Pediatrics to transmit my medical records to the email address provided above using a secure, encrypted method. I understand that I am responsible for providing an accurate email address and for maintaining the security of my email account. Once records are received, downloaded, or forwarded by me, they may no longer be protected under HIPAA. **Patient/Parent/Guardian Initials: _____**
Email Address: _____

□ Complete Paper Copy of Medical Records sent via certified mail – *Charge of $20.00 to be paid at time of request.*
(We will provide one copy of medical records. No additional copies will be provided.)

□ Records transmitted via fax to the healthcare provider listed above under "Organizations/Persons Receiving the Information."

□ Other: _____

Please allow 5 business days for processing. Records will be provided according to the delivery method selected above.

IF LEAVING PRACTICE, PLEASE SPECIFY WHY: _____

Please be advised, once your records are transferred for purpose of primary care provider change, your child will no longer be a patient of Oberlin Road Pediatrics.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____

I understand that Oberlin Road Pediatrics may deny my request to inspect or obtain copies of my protected health information (PHI) in certain circumstances permitted by law. If denied, I may request a review of the decision. I understand that I may revoke this Authorization at any time by providing written notice to Oberlin Road Pediatrics; however, the revocation will not apply to information already released in reliance on this Authorization. Unless otherwise specified, this Authorization will expire 180 days from the date of signature. I have the right to receive a copy of this Authorization. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I have reviewed and understand this authorization: (Print Full Name) _____
Patient/Parent/Guardian Signature: _____ Date: ___/__/___

Office Use Only: Date Information Disclosed/Released: _____/_____/____ Initials _____ Patient No. _____