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

(Please complete for all authorizations)

I hereby authorize the use, release and/or disclosure of my health information as described below. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy regulations.

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._____

I authorize this information to be sent to the above address:

- ☐ Complete Medical Records from Oberlin Road Pediatrics – *Charge of $15.00 to be paid at time of request.*
- ☐ Copies of all Medical Records from previous Pediatric Practice (or other medical facilities)
- ☐ Immunization Records Only
- ☐ Other (Please Specify) _____

IF LEAVING PRACTICE, PLEASE SPECIFY WHY: _____

BY REQUESTING THE RELEASE OF MEDICAL RECORDS FOR THE ABOVE STATED PATIENT, I UNDERSTAND THAT OBERLIN ROAD PEDIATRICS WILL TERMINATE THEIR MEDICAL CARE RESPONSIBILITY EFFECTIVE 30 DAYS FROM RECEIPT OF THIS AUTHORIZATION.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____

Oberlin Road Pediatrics may deny in writing your request to inspect and/or copy your PHI in limited circumstances. You may request a review of our denial in writing. Another licensed health care professional, chosen by us, will conduct a review of our denial.

You may revoke this authorization at any time by notifying Oberlin Road Pediatrics. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

Unless revoked earlier or earlier or otherwise indicated, this authorization will expire in 180 days from the date signed.

You may request or copy the protected health information to be used or disclosed.

Oberlin Road Pediatrics assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization.

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. _____