AUTHORIZATION For USE, DISCLOSURE and/or REQUEST of PROTECTED HEALTH INFORMATION

Pediatric Release Form

2421 Silver Stream Ln
Wilmington, NC 28401
Phone: 910-341-3308
Fax Release Form to: 910-341-3419
Fax Records to: 910-341-1900

SECTION A: Psychotherapy Notes.

☐ Check if this authorization is for psychotherapy notes. **If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information. Identify the psychotherapy notes by checking "Other" in Section C and describing in the space provided, do not check any other boxes or types of information.**

SECTION B: The Individual (or the Individual's Personal Representative) confirming the authorization.

I authorize the use and/or disclosure of my protected health information as described in Section C below. I understand that this authorization is voluntary.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Patient's Name: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Telephone: _____ **E-mail**: _____

Date of Birth: _____ **Social Security # (last 4 digits only)**: _____

SECTION C: The use, disclosure and/or request information being authorized:

☐ All **Pediatric records (Birth to Present)**
☐ Present year only ☐ 1 year ☐ 2years **Office Notes**
☐ Present year only ☐ 1 year ☐ 2years **Lab Results**
☐ All **Well Child Exams** ☐ Last **Eye/Vision Exam** ☐ Last **Hearing Exam/Test**
☐ All **Immunization** ☐ All **Radiologic studies** ☐ All **Pathology** reports
☐ All **Hospital Admissions, H&Ps**, **Consults**, **Operative Reports, Discharges**
☐ OTHER _____
_____

Entities Authorized to Use or Disclose:
Records requested **FROM:**
Name of provider or organization:

_____

Address _____

_____

Phone #: _____

Fax #: _____

Entities Authorized to Receive and Use:
Records to be **SENT TO**:
Name of provider or organization:

_____

Address_____

_____

Phone #: _____

Fax #: _____

SECTION D: Preference for Receipt of Records

☐ Regular Mail ☐ Fax:# _____(Maximum 50pgs)
☐ Pick up by: _____(minimum 2-3 day processing) Where: _____
☐ Retrieve from Website (Personal copies only)
☐ Electronic Copy (disk)

SECTION E: Purpose of Use, Disclosure and/or Request of Protected Health Information.

☐ Personal Use ***You will be charged a state regulated fee for a personal copy of records. ($10 minimum/$50 maximum).**
☐ Changing Provider/Continuity of Care ☐ Insurance ☐ Attorney
☐ Other _____

SECTION F: Expiration

This authorization will expire (complete one): ☐ 2 Years after my death
☐ Until I revoke permission in writing ☐ Future Date ____/____/_____ ☐
On the occurrence of the following event:
_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Wilmington Health Privacy Officer **Telephone:** (910) 796-7701
Fax: (910) 341-3419 **Address:** 1920 South 16th Street, Wilmington, NC 28401
E-mail: privacy@wilmingtonhealth.com

Inability to Condition Treatment: I understand that Wilmington Health may not condition my treatment on my refusal to sign this authorization.

SECTION F: SIGNATURE

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION AND REQUEST WILL BE CONSIDERED NULL & VOID.

PERSONAL COPIES WILL INCUR A FEE. REFER TO "SECTION E" FOR INFORMATION.

Signature: _____ **Date**: _____ If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

WITNESS: _____ **Date**: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
Include this authorization in the individual's medical record.

AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

I, _____, of _____ County, State of _____, am the custodial parent having legal custody of _____, a minor child, age _____, born _____. I authorize _____ of _____ County, State of _____, to do any acts which may be necessary or proper to provide for the health care of the minor child, including but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including the administration of anesthesia, x-ray examination, performance of operations, or other procedures by physicians, dentists, and other medical personnel, except the withholding or withdrawal of life-sustaining procedures.

This consent shall be effective from the date it is executed until the date I terminate it in writing.

By signing here I indicate that (i) I have the understanding and capacity to recognize the importance of, to communicate, and assign the health care decision covered by this document, (ii) I am fully informed as to the contents of the document, and (iii) I understand the full scope and importance of this grant of powers to the agent named herein.

_____ _____

(Custodial Parent's Signature) (Date)

STATE OF _____

COUNTY OF _____

On this _____ day of _____, 20_____, personally appeared before me the named _____, to me known and known to me to be the person described in and who executed to foregoing instrument and that person acknowledges that he or she executed the same and being duly sworn to me, made oath that the statements in the foregoing instrument are true.

_____, Notary Public

My Commission Expires: _____ (OFFICIAL SEAL)

Medical Record # _____