Little Oaks Pediatrics PLLC
RELEASE OF INFORMATION

13200 Strickland Road Suite 120 Raleigh NC 27613
Phone: 919-720-4876 Fax:855-861-0602

DATE: _____

FAXES PREFERRED/ CD

Please check one of the following options:

☐ I hereby authorize Little Oaks Pediatrics PLLC to ***release*** the following information from the medical record(s) of:

☑ I hereby authorize Little Oaks Pediatrics PLLC. to ***request*** the following information from the medical record(s) of:

NAME _____ Date of Birth _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ SOCIAL SECURITY NUMBER _____

Information to be released: Specific Dates _____ *All Records*

✓ Medical Summary and Specialist Consults
✓ Immunization Records
✓ Other-Please List Labs

Records are to be:

☑ Requested from (please indicate your previous doctors info below)

☐ Sent to

NAME _____

COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

Purpose of Disclosure:
___ Attorney/Legal
✓ Continued Patient Care
___ Personal Use
___ Commercial Insurance
___ Other (Specify)

I understand that such medical records may contain information regarding psychological, drug, and /or alcohol conditions, and /or diagnosis, treatment and care of sexually transmitted diseases or complications related to sexually transmitted diseases, including but not limited to HIV testing and results. I hereby authorize the release of such medical records pursuant to this authorization for release or request of medical records, and waiver confidentiality provisions pertaining to this release. I understand letters, correspondences, and copies of medical records from other health care providers will not be released.

Specification of the date, event, or condition upon which this consent expires: I understand that this consent is revocable, except to the extent that action has already been taken in reliance thereof. Request for revocation of this authorization must be in writing and presented to the Medical Records representative of Pediatric Associates of Mobile. This authorization will expire (i) after six months, (ii) after the disclosure is made, or (iii) the date specified here: _____ to accomplish to purpose of the disclosure state above

The employees and physicians are hereby released from any legal responsibility or liability for the release or request of the above information to the extent indicated and authorized herein. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected under Title 45, CFR. Pediatric Associates of Mobile may not condition treatment or payment on whether you sign this authorization. I understand that authorizing this disclosure of health information is voluntary.

Signature of Parent/Legal Guardian _____ Date _____

If Legal Representative, State Relationship _____

Patient Unable to Sign _____ Reason _____

Witnessed by _____

Date _____