Calvary Pediatrics
509 Sandhurst Drive
Fayetteville, NC 28304
Office # 910-484-4233 Fax # 910-484-2990

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Patient's Name: _____ Date of Birth: _____

I authorize: Name _____

Address _____

_____

Phone# _____ Fax # _____

To release the above named patient's health information as described below to CALVARY PEDIATRICS. **Please mail (DO NOT FAX) to Calvary Pediatrics, 509 Sandhurst Drive, Fayetteville, NC 28304.** I understand unless revoked earlier or otherwise indicated, this authorization will expire 30 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Description of the information to be used or disclosed (check all that apply):

( ) The Patient's Entire Medical Record. Purpose: ___ Changing Doctors ___ Co-ordination of Care

( ) Certain Medical Data/Information Related To:
- ( ) Date of Service (s): _____
- ( ) Specific Condition (s): _____
- ( ) Specific Service (s) Test (s) Procedure (s):
  - Lab: _____
  - X-Ray: _____
  - Immunizations: _____
  - Specific Office Visit (s)/Physical Exam (s): _____
  - Specific Medication (s): _____

( ) Other & Reason: _____
_____
_____

I DO ___ DO NOT ___ authorize the release of portions of the record relating to substance abuse, psycho-Logical/psychiatric condition and or communicable diseases, including AIDS/HIV infection.

_____

Parent/Guardian's Printed Name Signature Date

The information contained in this facsimile is privileged and confidential and is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is strictly prohibited. If you have received this information in error, please call us immediately and destroy the copy in your possession or return the entire transmittal to the address on this form via the U.S. Postal Service.