RELEASE OF INFORMATION

LITTLE OAKS PEDIATRICS, PLLC

13200 Strickland Rd Ste 120, Raleigh NC 27613
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DATE:_____

Please Check one of the following options:

- ❑ I hereby authorize Little Oaks Pediatrics PLLC to ***RELEASE*** the following medical information of:
- ❑ I hereby authorize Little Oaks Pediatrics PLLC to ***REQUEST*** the following medical information of:

NAME _____ Date of Birth_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER (_____)_____

Purpose of Disclosure:
__Attorney/Legal
__Continued Patient Care
__Personal Use
__Commercial Insurance
__Other (Specify)
_____
_____
_____

Information to be released:

_____ ALL RECORDS
_____ Specific Dates_____
_____ Medical Summary and Specialist Consults
_____ Immunization Records
_____ Other-Please List_____

Records to be:

- ❑ Requested from
- ❑ Sent to

Doctor/Office/Parent_____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Fax (_____)_____

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 content 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 the 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_____

Witnessed by_____ Date_____