Village Pediatrics & Internal Medicine

300 Market Street Ste.112
Chapel Hill, NC 27516
Phone: 919-969-9611
Fax: 919-969-9615

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name_______________________________________ Date of Birth________________

I authorize the use or disclosure of the above named individual's protected health information as described below.

Please send all medical records from Village Pediatrics to the Physician noted below:

Name:______________________________ Phone:________________________________

Address:____________________________ Fax: _________________________________

____

Purpose of Disclosure: __________*continuation of care* ____________________

I understand that this authorization will expire on ___________ or 6 months after the date as signed below.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer e-protected by Federal privacy regulations.

Signature of Patient/Parent/Legal Guardian ____

Relation to patient________________________ Date ___________________________

Village Pediatrics & Internal Medicine is a paperless clinic.
Please fax records to save paper & postage.

It Takes a Village...