Village Pediatrics of Chapel Hill

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

AUTHORIZATION FOR RELEASE OF INFORMATION

Please release records to Village Pediatrics of Chapel Hill, PA

Patient Name____ Date of Birth________________

I authorize the use or disclosure of the above named individual's protected health information as described below.
This information is to be released from (previous physician):

Name:_____________________________ Phone:_________________________________
Address:_____________________________ Fax: __________________________________
____

Information to be released: ____

Purpose of Disclosure: _________*continuation of care*________________

I understand that this authorization will expire 6 months after I have signed this form ________________.

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 is a paperless clinic.
Please fax records to save paper and postage.

It Takes a Village...