AUTHORIZATION FOR RELEASE OF INFORMATION

P.O. Box 87407 Fayetteville, NC 28304
P: (910) 486-5437 F: (910) 223-2630
Admin1@rainbowpeds.net

DATE: __________________

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I hereby authorize Rainbow Pediatrics to RELEASE the following medical information of:
☐ I hereby authorize Rainbow Pediatrics to REQUEST the following medical information of:

PATIENT NAME: ____ **DOB:** _______________

ADDRESS: ____

CITY: ________________________________ **STATE:** __________ **ZIP:** __________________

PHONE: (______)______________________

INFORMATION TO BE RELEASED:

☐ All Records
☐ Specific Dates ____________________
☐ Immunization Records
☐ Last Well Child Exam
☐ Other (please list): _______________________________

PURPOSE OF DISCLOSURE:

☐ Attorney/Legal
☐ Transferring Care
☐ Continued Patient Care
☐ Personal
☐ Other (Specify) ____________________

FORMAT:

☐ Paper
☐ Disc

VIA:

☐ Fax
☐ Email
☐ Mail
☐ Pickup from ____Robeson ____McPherson ____Hope Mills ____Raeford

RECORDS TO BE:

☐ Requested from
☐ Sent to

DOCTOR/OFFICE/INDIVIDUAL: ____

ADDRESS: ____

CITY:____ **STATE:** ___________ **ZIP:** ____________________

PHONE: (______)_______________________________ **FAX:** (______)________________________________

EMAIL: ____

I UNDERSTAND THE FOLLOWING:

My healthcare and the payment for my healthcare will not be affected by signing this form. Rainbow Pediatrics may condition the provision of healthcare that is solely for the purpose of creating PHI for disclosure to a third party, upon signing an authorization for disclosure of the PHI to such third party. Rainbow Pediatrics may condition the provision of research related treatment on provision of an authorization for the use or disclosure of PHI for such research. IF the requester or receiver is not a health plan or healthcare provider, the release information may no longer be protected by federal privacy regulations and may be re-disclosed. I may revoke this authorization at any time in writing. Revocation of this release will not have any effect on any actions previously taken. Rainbow Pediatrics will provide me with a copy of this signed authorization upon request. **Once the authorization is submitted for transfer of care, the patient will no longer be considered a Rainbow Pediatrics patient unless special approval is given.**

This consent will automatically expire 90 days from date of signature, unless another date is specified below.
*Authorization not valid beyond: _______________(Date cannot exceed one year from date of signature)

SIGNATURE:____ **DATE:** _________________

(Relationship)