[ ] 145 Tilghman Drive Suite 300
Dunn, NC 27334
Phone (910) 891-5437
Fax (910) 897-7145
[ ] 609 Attain Street Suite 181
Fuquay Varina, NC 27526
Phone (919) 557-5433
Fax (919) 557-6279

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME:_____ DOB:_____

I HEREBY AUTHORIZE_____
(NAME OF PRACTICE YOU ARE REQUESTING RECORDS FROM)

DATES OF CARE FROM/TO_____
[ ] A COMPLETE COPY OF MEDICAL RECORDS **OR**

[ ] SPECIFIED PROTECTED HEALTH INFORMATION NECESSARY FOR TREATMENT (Check all that applies)
[ ] IMMUNIZATIONS [ ] HISTORY AND PHYSICALS [ ] GROWTH CHARTS
[ ] LABS & XRAY REPORTS [ ] OTHER (Please Specify)_____

TO RELEASE TO EXCEL PEDIATRICS AT THE ADDRESS CHECKED ABOVE, INFORMATION CONCERNING THE HISTORY AND TREATMENT RECORDS FOR THE ABOVE PATIENT, FOR THE PURPOSE OF CONTINUITY OF CARE. I UNDERSTAND THAT THIS CONSENT IS REVOCABLE EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. THIS CONSENT WILL AUTOMATICALLY EXPIRE NINETY DAYS FROM THE DATE OF SIGNATURE.

_____ DATE_____
SIGNATURE OF PARENT, GUARDIAN OR LEGAL REPRESENTATIVE

_____
RELATIONSHIP TO PATIENT

_____ DATE_____
SIGNATURE OF WITNESS

* UNLESS OTHERWISE PERMITTED BY LAW, FURTHUR RELEASE OF THIS INFORMATION IS PROHIBITED WITHOUT MY PRIOR WRITTEN CONSENT.