THE CARITHERS PEDIATRIC GROUP

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of my child's medical record **TO/FROM** the Carithers Pediatric Group:

TO/FROM (CIRCLE ONE) **PATIENT'S NAME AND DATE OF BIRTH:**

Name: _____ _____

Address: _____ _____

City/State/Zip: _____ _____

Phone Number: _____ _____

My child (ren's) protected health information will be used by or disclosed to the person as indicated on this request for the following reason:

☐ Child is transferring due to age.
☐ Moving.
☐ Personal Use.
☐ Second Opinion.
☐ I am dissatisfied with this practice. Please Explain: _____

_____

_____

PLEASE PROVIDE YOUR MAILING ADDRESS IF YOU WOULD LIKE US TO MAIL YOUR MEDICAL RECORDS TO YOU.

Mail to: _____

_____

_____

I understand that information used and disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my child (ren's) protected health information.

I have read and understand the above statements and consent to the release as described above.

X _____
PRINTED NAME OF PARENT/LEGAL GUARDIAN SIGNATURE DATE

Please provide a phone number where we can reach you when records are ready to be picked up. _____

PLEASE NOTE: The charge for records is $1.00 per page up to 15 pages and a charge of $0.25 for each page after that. There is a minimum charge of $10.00 for all records.

X _____
RECORDS PICKED UP BY DATE