Salisbury Pediatric Associates, P.A.
129 Woodson St.
Salisbury, NC 28144
(704) 636-5576 Phone
(704) 636-1755 Fax

Authorization to Use, Release, and/or Disclose Protected Health Information

Upon completion of this form, I understand that Salisbury Pediatric Associates, P.A. is authorized by me to use, release, and/or disclose the Protected Health Information (PHI) as described below. I understand the information disclosed, pursuant to this Authorization, may be subject to disclosure by the recipient, and no longer protected by the Privacy regulations.

Patient's Name: _____ Date of Birth: _____

Last 4 of Patient's Social Security#:_____ Phone #:_____

RELEASE FROM:	**RELEASE TO:**
Name: _____	**Name: _____**
Address: _____	**Address: _____**
_____	**_____**
Phone #: _____	**Phone #: _____**
Fax #: _____	**Fax #: _____**

I authorize the following information to be sent to the above address: (Check all that apply)

- ☐ Copies of Medical Records for the period: __/__/__ to __/__/__
- ☐ History & Physical Examination
- ☐ Reports from other physicians
- ☐ Lab, X-Ray, etc. reports
- ☐ Other (Please specify _____
- ☐ The following information should **NOT** be released: (Please specify)_____

Reason for transfer/disclosure: _____

I understand that:

- I may revoke this authorization at any time by notifying the Practice's HIPAA Privacy Officer in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. I may request or copy the protected health information to be used or disclosed.
- This authorization will expire one year from today's date unless otherwise specified.
- Salisbury Pediatric Associates, P.A. assumes no responsibility for the use or misuse by others of my (child's) health information disclosed under this authorization.

I have read and fully understand Salisbury Pediatric Associates Medical Record Release Policies and Procedures.

Patient/Parent/Guardian Signature: _____ Date: _____

PLEASE ALLOW 21 BUSINESS DAYS FOR ALL MEDICAL RECORDS REQUESTS

*****You may incur a charge for copying your medical records. If so, it is applied in accordance with NC state law.*****

OFFICE USE ONLY

Date Request Received: _____ Date Information Disclosed: _____

Patient Account # _____ Staff Initials: _____ HIPAA Officer Review: _____