CHAPEL HILL CHILDREN'S CLINIC

301 Kildaire Rd., Ste. 200, Chapel Hill, NC 27516
PH: (919) 967-0771 FAX: (919) 967-9207

**** If over 20 pages, please fax to: (888) 242-6706***

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
OFFICE CONTACT: FRONT DESK ADMINISTRATIVE STAFF

I hereby authorize use or disclosure of the named individual's health information as described below:

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: (street, city, state, zip code)

_____

I authorize **Chapel Hill Children's Clinic** to **obtain** Protected Health Information from:

_____
Name of Physician's Office or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

I authorize **Chapel Hill Children's Clinic** to **disclose** Protected Health Information to:

_____
Name of Physician's Office or Individual

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

Treatment Dates: _____ Purpose of Request: _____

The following information is to be disclosed: (please check one box for each item)

YES	NO		YES	NO	
□	□	Chart Summary	□	□	X-Ray Reports
□	□	Immunization Records	□	□	Complete Record
□	□	Physician Notes	□	□	Other: _____
□	□	Lab Results			

SENSITIVE INFORMATION: I understand that the information in my or my child's record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the human immunodeficiency virus (HIV). It may also include behavioral or mental health services or treatment for alcohol and drug abuse. Telephone notes and portal messages are not included in printed/faxed/saved to an electronic format for disclosure Medical Records per office policy.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I also understand that the revocation will not apply to information already released based on this authorization.

OTHER RIGHTS: (a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. (b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

READMISSION: Please be advised that by signing this form requesting records you are legally withdrawing from our practice. Chapel Hill Children & Adolescents' Clinic will continue to prioritize the needs of our current patients, which includes convenience in scheduling, and ready access to preferred physicians. Consequently, we cannot guarantee readmission to the practice at any given time. Requests for readmission will be reviewed on a case by case basis, and at the sole discretion of the practice.

AGE FOR SIGNATURE: If your child is over the age of 12, they must sign for their own records. Privacy laws protect your child's records, and certain conditions/tests/diagnoses are protected from even their parents/guardians without their consent. Please respect our rules in protecting your child's privacy.

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (if I do not specify an expiration date, event, or condition, this authorization will expire in twelve months.) Expiration date: _____

Signature of Patient (if over the age of 12) or Legal Representative: Date:

_____ _____

If signed by Legal Representative, Relationship to Patient:

_____