



# Medical Record Release Authorization

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### A) I hereby authorize records FROM:

### B) To be released TO:

#### TRIANGLE PEDIATRIC CENTER

105 RIDGEVIEW DRIVE

CARY, NC 27511

Phone#: 919-467-5543 Fax#: 919-469-2391

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

- \_\_\_\_ Litigation                      \_\_\_\_ Moving
- \_\_\_\_ Insurance                      \_\_\_\_ Self/Personal Copy
- \_\_\_\_ Continuity of Care              \_\_\_\_ Aging Out
- \_\_\_\_ Dissatisfied w/ Practice (provide details):  
\_\_\_\_\_

Date Range _____ to _____	
<input type="checkbox"/> Physician Office Notes	<input type="checkbox"/> Cardiology/Radiology
<input type="checkbox"/> Immunizations	<input type="checkbox"/> Lab/Path Reports
<input type="checkbox"/> Operative/Procedure Reports	<input type="checkbox"/> Minimum Necessary
<input type="checkbox"/> Other _____	<input type="checkbox"/> <b>All Records</b>

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Patient/Parent/Guardian or Authorized Representative) **\*\*Subject to Fees**

This authorization will expire one year from the above date unless I specify an expiration date: \_\_\_\_\_  
(Expiration date of authorization)

**\*PLEASE READ Fee Information:** Triangle Pediatrics reserves the right to charge the medical record state fee structure as set forth in the state statute. Copy charges plus postage will be invoiced to you with all necessary directions to receive your records. By signing this authorization, you are agreeing to pay Triangle Pediatric Center, P.A. for your records. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy.

[Medicalrecords@tripeds.com](mailto:Medicalrecords@tripeds.com)