REQUEST FOR RECORDS RELEASE

RALEIGH CHILDREN
AND ADOLESCENTS MEDICINE

1. Request for records to be released <u>from another facility **TO** Raleigh Children & Adolescents Medicine</u>:

"I authorize…" (*listed below*)	*"to release medical records to…"* (*listed below*)
Facility	*Facility* RALEIGH CHILDREN AND ADOLESCENTS MEDICINE
Address	*Address* 3100 Duraleigh Road, Suite 300
Address	*Address* Raleigh, NC 27612
Telephone *Fax*	*Telephone* 919-781-7490 *Fax* 919-783-0903

2. Request for records to be released **<u>FROM</u>** Raleigh Children & Adolescents Medicine to another facility:

"I authorize…" (*listed below*)	*"to release medical records to…"* (*listed below*)
Facility RALEIGH CHILDREN AND ADOLESCENTS MEDICINE	*Facility*
Address 3100 Duraleigh Road, Suite 300	*Address*
Address Raleigh, NC 27612	*Address*
Telephone 919-781-7490 *Fax* 919-783-0903	*Telephone* *Fax*

3. Purpose for release of records (please check ☑ all that apply):
   - ☐ Medical follow-up with a specialist
   - ☐ Legal
   - ☐ Transfer to another practice:
     - ☐ Purpose of transfer is a move (moving where?):
     - ☐ Purpose of transfer is a change in insurance (what insurance?):
     - ☐ Purpose of transfer is (please list why):
   - ☐ Other (please list why):

4. The cost for a summary of medical records is $20 per child. Please allow 2-3 weeks to process this request.

5. My signature below authorizes the release of medical records for each child listed:

Child's Name	*Date of Birth*	*Child's Name*	*Date of Birth*
1.		3.	
2.		4.	

Signature of Parent / Guardian / Patient ≥ 18 years old *Relationship to Patient* *Date*