



Release of Information Authorization (Medical Records Request)

Date: _____

I _____ authorize the release of all medical record for the purposes of continuity of care **FROM:**

Provider Name

Address

Phone

Fax

TO

TRIANGLE KIDS CARE PEDIATRICS, PLLC
216 Ashville Ave, Suite 60
Cary, NC 27518
Ph: 919-655-7873
Fax: 919-535-9205

for my child(ren) listed below:

Patient Name: _____ DOB: _____

Signatures

Relationship to Patient

Date