# Release of Information Authorization
## (Medical Records Release)

Date:_____

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

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

**TO:**

_____ _____
Provider Name Address

_____ _____
Phone Fax

for my child(ren) listed below:

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

_____ _____ _____
Signatures Relationship to Patient Date