Carolina Pediatrics of Wilmington, P.A.
715 Medical Center Drive, Wilmington, NC 28401

Fax #: 910-763-8176 Phone #: 910-763-2476
E-mail: medicalrecordswilm@carolinapedswilm.com

Wilmington Office ☐ **Hampstead Office** ☐

Authorization for Use and/or Disclosure of Protected Health Information

Section A: The Individual (or the Individual's Personal Representative) confirming the authorization

I authorize the use and/or disclosure of my protected health information as described in Section C below. I understand that this authorization is voluntary. I understand that, if the person or organization I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted disease; HIV infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions. I understand that there may be information in these records that I would not want released.

Patient Name: _____ DOB: _____ Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____ Patient Name: _____ DOB: _____

Section B: Information to be released or disclosed is:

☐ **Immunization records** ☐ **Complete records** ☐ **Other** _____

Send or Release records FROM:

Name: _____
Address: _____
_____
Phone #: _____
Fax #: _____

Send or Release records TO:

Name: Carolina Pediatrics of Wilmington
Address: 715 Medical Center Dr.
Wilmington, NC 28401
Phone#: (910)763-2476
Fax #: (910)763-8176

Primary Insurance: _____ **Secondary Insurance (If applicable):** _____

Section C: Purpose of Use or Disclosure of Protected Health Information

☐ Personal Use ☐ Physician Communication ☐ Changing Provider ☐ Insurance ☐ Attorney ☐ Other _____

******Please be advised, once your records are transferred, for purpose of primary care provider change, your child will no longer be a patient of Carolina Pediatrics******

I understand that this authorization shall be valid for a year. That I may revoke this consent anytime except to the extent that action has already been taken.

I understand that Carolina Pediatrics may not condition my treatment on my refusal to sign this authorization.

Patient or legally authorized individual's signature: _____ Date: _____

Print Name: _____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc…) :

_____

Parent / Guardian Address: _____

Contact Phone Numbers: _____ Home _____ Cell _____ Other

Email: _____

Please note that any medical records received via non-encrypted email is the responsibility of the sender – not Carolina Pediatrics of Wilmington, P.A.