

PLEASE TRANSFER ALL MEDICAL RECORDS FOR THE PATIENT(S) LISTED BELOW.
THANK YOU FOR YOUR

PROMPT ATTENTION IN TRANSFERRING THESE RECORDS.

I, _____ hereby request and authorize Kernersville
Pediatrics/

Winston-Salem Pediatrics to release the following records to:

(Doctor's Name or Practice)

(Address)

(Phone)

(Fax)

(Child's Name)

(Date of Birth)

Notice: This authorization is for a medical summary unless otherwise requested by
parent/legal guardian for entire record

(\$25.00 fee). Entire record includes all records, clinical findings, diagnosis,
treatment, assessment, recommendations for

further care, names of health care personnel, dates of hospitalization and
ambulatory visits. It also includes any

information that may be related to drug, alcohol, psychiatric conditions, and/or
sexually transmitted diseases,

including HIV/AIDS information.

This authorization provides that:

- I may revoke the authorization at any time, provided that the revocation is in writing except if this practice has taken action relying on this consent, or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA privacy rules.
- I have the right to access my protected health information to be used or disclosed.

The facility, its employees, and providers are hereby released from any legal responsibility for the disclosure of the above requested information to the extent indicated and authorized herein.

Parent/Legal Guardian Signature

Date

Phone