WINSTON-SALEM Pediatrics

REQUEST FOR TRANSFER OR RELEASE OF HEALTH INFORMATION

WINSTON-SALEM Pediatrics

Patient Name _____ **Date of Birth** ____ / ____ / ____

I hereby authorize and request that, for the child listed above, the following medical records be released for the purpose of

(Check One) ☐ **Transfer (Reason)** _____ ☐ **Personal Copy** ☐ **Other** _____

The information is to be released from the following (Check One):

☐ **FROM Winston Salem Pediatrics** ☐ **FROM** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Phone (_____) _____-_____ **Fax** (_____) _____-_____

The information is to be released to the following (Check One):

☐ **TO Winston Salem Pediatrics**
2808 Maplewood Avenue
Winston-Salem, NC 27103
(336) 765-9000
(336) 765-5702

☐ **TO** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Phone (_____) _____-_____ **Fax** (_____) _____-_____

☐ **Personal Copy** ☐**Mail to** **Address** _____

City _____ **State** _____ **Zip Code** _____

☐**Fax to** (_____) _____-_____

☐ **Pick Up Date** ____ / ____ / ____

□ **Patient Summary (Free)** □ **Entire Record ($25.00)** □ **Paid** □ **Not Paid** **Initials** _____
(See Back for Patient Summary and Entire Record Differences)

□ **Lab/Test** _____ **Results** □ **Physician Notes** **From** ____ / ____ / ____ **To** ____ / ____ / ____

□ **Other** _____

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 content, or is 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 HIPAA 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. All records including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of health care personnel, dates of any information that may be related to drug, alcohol, hospitalization and ambulatory visits. It also includes psychiatric conditions, and/or sexually transmitted diseases, including HIV/AIDS information.

This release may include drug, alcohol, psychiatric, and sexually transmitted disease information unless indicated here_____. This release expires within 6 months unless indicated here _____.
By signing this form, I am releasing Winston-Salem Pediatrics from all liability in connection with the release of those records to another party.

_____ _____ ____ / ____ / ____

Parent/Legal Guardian if Under 18 Signature **Printed Name** **Date**

Records	**Patient Summary (Free)**	**Entire Record ($25.00)**
Allergies	Included	Included
Calls	--	*All*
Growth Charts	Included	Included
Immunization Records	Included	Included
Labs/Tests	*Most Recent*	*All*
Past Medical History	Included	Included
Physical Exams	*Most Recent*	*All*
Referrals	--	*All*
Social History	Included	Included