

11130 Capital Blvd.

INCOMING RECORDS



Wake Forest, NC 27587
 (p) 919.488.4094
 (f) 919.488.4096

270 Horizon Dr.
 Raleigh, NC 27615
 (p) 919.845.0623
 (f) 919.488.1716

1005 Big Oak Ct.
 Knightdale, NC 27545
 (p) 919.266.5669
 (f) 919.488.1717

500 Gateway Dr.
 Clayton, NC 27520
 (p) 919.585.9001
 (f) 919.488.1719

116 East Horton St.
 Zebulon, NC 27597
 (p) 919.269.2885
 (f) 919.488.1718

7990 Arco Corporate Dr.
 Shoppes at Brier Creek
 Raleigh, NC 27617
 (p) 919.544.5900
 (f) 919.488.1455

4551 New Bern Ave.
 Raleigh, NC 27610
 (p) 919.861.7793
 (f) 919.488.1458

Kid's Express Care
 (p) 919.861.1636
 (f) 919.488.1456

Authorization for Request and Use of Health Information

(This form applies only to the receipt and use of information. It is not consent for treatment or intended for any other purpose)

By signing this form, I authorize Growing Child Pediatrics, PA to request and use the protected health information described below for:

Patient's Name: _____

DOB: _____

Name of person/organization from whom information should be requested:

Address of person/organization from whom information should be requested:

Phone and fax numbers of person/organization from whom information should be sent:

Purpose of request (at request of patient, employment, life or disability insurance, etc.):

I authorize the following information to be requested from the address above:

___ Copies of all medical records for the period ___/___/___ to ___/___/___

___ Other (please specify) _____

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (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.

I have been provided a copy of Growing Child Pediatrics, PA's Notice of Privacy Practices and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, and disclosure of my health information with Growing Child Pediatrics, PA's Privacy Officer or other appropriate office personnel.

I understand that Growing Child Pediatrics, PA assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Growing Child Pediatrics, PA from all legal liability that may arise from this authorization.

Patient or legally authorized individual's signature: _____

Date: _____ SSN: _____ DOB: _____

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

The patient or their representative may revoke this authorization by notifying in writing Growing Child Pediatrics, PA's designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if the Privacy Rule prohibits such conditioning. Federal law also requires a statement that there is the potential that the protected health information released under this authorization may be subject to redisclosure by the recipient. (HK REV. 6/07)