656 Carpenter Avenue
Mooresville, NC 28115
704-664-5133
FAX 704-660-0406

Amy P. Ferguson, MD FAAP
Gianna D. Madrid, MD, FAAP
Karen S. Mayhew, PA-C AAPA
Laura O'Donnell, MD
Robin C. Ray, MD
Kevin D. Wellbaum, MD

Authorization to Release Protected Health Information

I hereby authorize Lake Norman Pediatrics to obtain medical records on the patient listed below through the release of PHI as described below. I understand the information disclosed, pursuant to this Authorization, may be subject to disclosure by the recipient, and no longer protected by the privacy regulations.

Patient's Name:____ **Date of Birth:** _________________________

Release From:	**Release To:**
Practice	Practice: **Lake Norman Pediatrics**
Address:	Address: **656 Carpenter Ave.**
	Mooresville, NC 28115
Phone:	Phone: **704-664-5133**
Fax:	Fax: **704-660-0406**

This authorization permits Lake Norman Pediatrics to use or disclose the following PHI (Protective Health Information). Check the appropriate box or describe the information to be released.

☐ Entire record ☐ Immunization Record ☐ Pathology Reports ☐ Laboratory Reports
☐ Copy of Medical Records for the period ____/_____/_____ to _____/_____/_____
☐ Other (Please Specify) ____

☐ **I do** ☐ **I do not** authorize release of information related to AIDS, HIV, psychiatric care and/or psychological assessment and treatment for drug and/or alcohol abuse.

PURPOSE OF DISCLOSURE:

☐ Transferring Physicians ☐ Insurance ☐ Moving ☐ Legal Purpose ☐ Patient Request-No Reason ☐ Personal
☐ Other____

I understand that:

- I may revoke this authorization at any time by notifying the Practice's HIPAA Privacy Officer in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. I may request or copy the protected health information to be used or disclosed.
- This authorization will expire one year from today's date unless otherwise specified.
- Lake Norman Pediatrics assumes no responsibility for the use or misuse by others of my (child's) health information disclosed under this authorization.
- This release form is valid 12 months from the date below.

Patient/Parent/Guardian Signature:____**Date:** ______________