Lake Norman Pediatrics

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 Use, Release, and/or Disclose Protected Health Information

Upon completion of this form, I understand that Lake Norman Pediatric is authorized by me to use, release, and/or disclose the Protected Health Information (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: **Lake Norman Pediatrics**		Practice:
Address: **656 Carpenter Ave.**		Address:
Mooresville, NC 28115		
Phone: **704-664-5133**		Phone:
Fax: **704-660-0406**		Fax:

I Authorize Lake Norman Pediatrics to release medical information to the above address: (Check all that apply)

☐ 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:

☐ Referral to Specialist ☐ Insurance ☐ Change of Physician ☐ Laboratory Reports ☐ Legal
☐ Disability ☐ 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.

Patient/Parent/Guardian Signature:_____**Date:** _____

PLEASE ALLOW 21 BUSINESS DAYS FOR ALL MEDICAL RECORDS REQUESTS

*****You may incur a charge for copying your medical records. If so, it is applied in accordance with NC state law.*****