Authorization for Disclosure of Health Information (OUTGOING medical records)

I, the undersigned, authorize Sandhills Pediatrics,Inc Medical Records Dept at 195 W Illinois Ave, Southern Pines NC 28387 to release my health information as noted below.

Patient name_____ Date of Birth_____

Address: _____ Phone #_____

City:_____ State_____ Zip:_____ Email_____

Release Information TO:

Name:_____ Attention:_____

Address_____ Phone_____

City:_____ State_____ Zip:_____ FAX _____

Purpose of Request: ☐ Personal ☐Treatment ☐Legal ☐ Insurance ☐ Disability

☐ Transfer (reason) _____

Information to be released:

Please specify the information to be released: ☐ *Immunization only* ☐ *Last Physical exam*

☐ *Entire chart* ☐ *specific info/dates:* _____

Any record release less than 15 pages is free. Transfer of records to another doctor is free. Other releases may be subject to the charges below.

*** NC Statute 90-4111: $0.75/pg for first 25 pages, $0.50/pg for pages 26-100, $0.25/pg for pages over 100*

(charges outlined above will be applied to copies released directly to patient. Charge may not apply when records sent directly to healthcare provider for ongoing treatment purposes)

***NOTE: I understand I will receive an invoice from BACTES imaging per NC law and payment is made directly to BACTES Imaging solutions. Questions about your request or invoice can be answered at 1-877-270-4365

_____ **Initial Here**

Authorization to release protected information

***Required- Please CIRCLE DO/Do Not options below indicating how protected information should be handled even if the categories do not appply to the patient's medical records. (Initial each line)

I **DO/** Do **NOT** want information about ***Mental Health** released _____

I **DO/** Do **NOT** want information about ***HIV tests and related info** released _____

I **DO/** Do **NOT** want information about ***Alcohol and substance Abuse** released _____

I **DO/** Do **NOT** want information about *_____ released _____

*other sensitive information

**(please make sure you circled Do/do NOT AND initialed each line. If form incomplete we might not be able to fulfill request)

Signature of Parent or Legal Guardian: _____Date:_____

(required for all patients under age 18 unless otherwise allowed by law. If not parent, legal documentation must be supplied)

Parent's signature: _____Date:_____

(required for all patients 18 years old and older. 18 years and older for psychiatric records, 14 years and older for substance abuse records)

* This authorization will expire 1 year from the date appearing above. I understand I may revoke this authorization at any time by notifying the Health Information Mgt Dept in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation.)

* I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipent and no longer subject to the protections of the privacy standard.

* I understand that my treatment or continued treatment by **Sandhills Pediatrics, Inc. and its affiliates is** in no way is conditioned on whether or not I sign the authorization and that I may refuse to sign it.

* I understand I may inspect or copy the information that is used or disclosed.