Shore FUN Pediatrics

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ Parent/legal guardian of:

Name_____ Date of Birth_____

Authorize:

_____

_____

_____

To release medical record information for continued medical treatment to:

SHORE FUN PEDIATRICS
14 DOCTORS CIRCLE, SUITE 3
SUPPLY, NC 28462
Fax: (888) 371-6181

Please choose one: **All Pediatric Records (Birth to Present)** _____

Other: _____

_____ (Patent/Guardian initial) I understand that my child's records may contain sensitive information in regards to substance abuse, mental health, HIV diagnostic records or other information. I hereby authorize disclosure of the health information for the above named patient/patients. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request and it will not effect any information released prior to cancellation of notification. I understand that the information used or disclosed may be subject to re-disclosure by the person/persons or facility receiving it and would then no longer be protected by federal regulations.

Parent/Guardian Signature: _____

Relationship to patient: _____ Date signed: _____

Current mailing address: _____

Home phone number: _____ Cell phone number: _____

Witness:_____ Date signed: _____