

North Raleigh Pediatric Group  
Medical Release Form

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

→Please select the box (□) that describes what type of transfer of records is needed:

I authorize:

\_\_\_\_\_  
Facility Name

\_\_\_\_\_  
Facility Address

\_\_\_\_\_  
Facility Address

\_\_\_\_\_  
Facility Address

→to release Medical Records to←

North Raleigh Pediatric Group  
7205 Stonehenge Drive  
Raleigh, NC 27613  
Tel-919-848-2229 Fax-919-848-8238

I authorize:

North Raleigh Pediatric Group  
7205 Stonehenge Drive  
Raleigh, NC 27613  
Tel-919-848-2229 Fax-919-848-8238

→to release Medical Records to←

\_\_\_\_\_  
Facility Name

\_\_\_\_\_  
Facility Address

\_\_\_\_\_  
Facility Address

\_\_\_\_\_  
Facility Address

**Purpose for release of Records:**

- Medical follow up with a specialist
- Legal
- Copy for Self
- Other (please list why): \_\_\_\_\_

- Transfer to another practice
- \_\_\_ Move
- \_\_\_ to Adult Medicine
- \_\_\_ Other Reason \_\_\_\_\_

**This data shall include: (check)**

- \_\_\_ Medical Summary (immunizations, last Physical, growth charts, problem list)
- \_\_\_ Complete Records- \$15 charge
- \_\_\_ Other

**Specific authorization for release of information protected by state and federal law:**

I hereby authorize the release of data and information relating to: (check any that may apply)

- Substance abuse, if any     Psychiatric/mental health, if any,
- HIV/AIDS, if any.

I understand that I may revoke this authorization at any time (by notifying North Raleigh Pediatric Groups designated privacy officer), and that unless an earlier date is specified, it will automatically expire 90 days after the date affixed below. A copy of this authorization is as valid as the original.

Signature of patient/parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Patient must sign if they are 18 years older