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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ DOB: _____

I HEREBY AUTHORIZE _____
 (NAME OF PRACTICE YOU ARE REQUESTING RECORDS FROM)

DATES OF CARE FROM/TO _____

- A COMPLETE COPY OF MEDICAL RECORDS **OR**
- SPECIFIED PROTECTED HEALTH INFORMATION NECESSARY FOR TREATMENT (Check all that applies)
- IMMUNIZATIONS HISTORY AND PHYSICALS GROWTH CHARTS
- LABS & XRAY REPORTS OTHER (Please Specify) _____

TO RELEASE TO EXCEL PEDIATRICS AT THE ADDRESS CHECKED ABOVE, INFORMATION CONCERNING THE HISTORY AND TREATMENT RECORDS FOR THE ABOVE PATIENT, FOR THE PURPOSE OF CONTINUITY OF CARE. I UNDERSTAND THAT THIS CONSENT IS REVOCABLE EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. THIS CONSENT WILL AUTOMATICALLY EXPIRE NINETY DAYS FROM THE DATE OF SIGNATURE.

 SIGNATURE OF PARENT, GUARDIAN OR LEGAL REPRESENTATIVE

DATE _____

 RELATIONSHIP TO PATIENT

 SIGNATURE OF WITNESS

DATE _____

* UNLESS OTHERWISE PERMITTED BY LAW, FURTHER RELEASE OF THIS INFORMATION IS PROHIBITED WITHOUT MY PRIOR WRITTEN CONSENT.