the ChildHealth Center, P.A.

Kenneth V. Summer, M.D.F.A.A.P.
Laura J. Luckadoo, M.D.F.A.A.P.
Tatyana V. Golub, M.D.F.A.A.P.
Angela M. Frierson, M.D.F.A.A.P.
Anna Shamsnia, M.D.F.A.A.P.
Denise E. Niehues, P.A.-C
Seth A. Abel, PA-C
Ann M. Adams, PA-C
Misty S. Cline, FNP-C
Tonya P. Manus, FNP-C

1455 25th Avenue Drive, NE, Hickory, NC 28601 — Phone: (828) 322-4453 — Fax: (828) 324-9295
Records Email: celliott@thechildhealthcenter.com

Authorization For Release of Medical Information

Patient's Full Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

I hereby authorize and request The ChildHealth Center, P.A.
to obtain information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone#/Fax# (include area code)/Email

Medical Information to be released: ___All records concerning previous history, evaluation and treatment (including immunization record)
___Other_____

Purpose for this request: (Check one)___Personal Copy ___Legal ___Insurance ___Continuation of Care
___Dissatisfaction (Reason)_____
___Other (specify)_____

FORMAT AND DELIVERY OF INFORMATION

Preferred Method of Delivery: CD or Encrypted Email (celliott@thechildhealthcenter.com) or USB Flash Drive

Other Methods of Delivery: Fax (**only if less than 50 pages**)

Mail (**if 50 pages or more**)

I do hereby consent and authorize you to release copies of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information, and any information relating to HIV testing, AIDS, and any AIDS related syndromes. It also includes any information concerning cancer, cancer testing and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as the original release. Please send copies of all requested information as soon as possible to the address listed above.

I understand that I may revoke this Authorization in writing at any time, except to the extent that action has already been taken in response to the Authorization. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law. I understand that I may refuse to sign this Authorization. A reasonable cost-based fee may be charged for copies of records being requested. I also understand that the release of information can take anywhere from 7-10 business days.

_____ _____
Signature of Patient or Legal Guardian Date*

_____ _____
Print Name of Patient or Legal Guardian Relationship to the patient

*Release request expires 90 days from signature date.