

Name:
Chart:
Age:

DOB:
Date:

SANDHILLS PEDIATRICS, INC.

195 West Illinois Avenue
Southern Pines, NC 28387
910-692-2444 Phone
910-692-3651 Fax

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

By signing this authorization, I authorize:

Doctor/Clinic/Guardian: _____
Address: _____
Phone: _____ Fax: _____

To Release to:

Doctor/Clinic/Guardian: _____
Address: _____
Phone: _____ Fax: _____

Specific Information to be disclosed/exchanged (check **ALL** that apply):

____ All medical records ____ Labs **ONLY**
____ Immunizations **ONLY** ____ Last PE
____ ADHD records **ONLY** ____ Other (specify) _____
____ Newborn records

Specific Information to be used or disclosed for the following purpose:

____ Transfer of Care ____ At the request of the individual
____ Patient Care

This authorization will expire in 90 days.

I do not have to sign this authorization in order to receive treatment from Sandhills Pediatrics, Inc. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer.

Patient Name _____ D.O.B. _____

Patient Name _____ D.O.B. _____

Patient Name _____ D.O.B. _____

Signed by: _____
Signature of Patient/Legal Guardian *Relationship to Patient*

Print Name: _____ Date: _____