



**Coastal  
Children's  
Clinic**

*Excellence in Pediatrics For Over 50 Years!*

**New Bern**

703 Newman Rd  
New Bern, NC 28562  
v(252)-633-2900  
f(252)633-9609  
Monday-Friday 8-5  
Sat 8-12; Sun 12-4

**Havelock**

218 Stonebridge Sq  
Havelock, NC 28532  
v(252)447-8100  
f(252)447-1900  
Monday-Friday 8-5  
**WWW.COASTALCHILDRENS.COM**

**Maysville**

1004 Jenkins Ave  
Maysville, NC 28555  
v(910)743-2022  
f(910)743-1283  
Monday-Friday 8-5

**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION  
TO COASTAL CHILDREN'S CLINIC**

**I hereby authorize** (previous doctor's office): \_\_\_\_\_

Previous Doctor's Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax: \_\_\_\_\_

**to disclose the following information::**

- ✓ **Immunization, Growth Chart,  
Problem Summary List**

Said authorization is given for the following purpose or need: TRANSFER CARE

I further authorize request to photocopy or otherwise reproduce said records for transmittal to:

Coastal Childrens Clinic  
703 Newman Road  
New Bern, NC 28562

Coastal Childrens Clinic  
218 Stonebridge Square  
Havelock, NC 28532

Coastal Childrens Clinic  
PO Box 160  
Maysville, NC 28555

These medical records will be released to the parent / guardian, after review.

I have been informed that the requestor will not release any information about me to any person or agency other than those stated above. This authorization shall remain valid until \_\_\_\_\_ (Date or Defined Event) and will expire without further notice or condition. If no date is given, then this is valid until purpose is fulfilled up to one year.

I understand that this information may include any history of acquired immunodeficiency syndrome; sexually transmitted diseases, human immunodeficiency virus infection; behavioral care; treatment for alcohol and/or drug abuse or similar conditions. I understand and have been informed that I have the right to receive a copy of this authorization and acknowledge receipt of the same if so demanded. \_\_\_\_\_.(Requester's Initials)

\_\_\_\_\_  
Chart # Patient's Name (one release per child) Date of Birth

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Please Print Name of Parent or Legal Guardian

Signature: \_\_\_\_\_

The patient or representative may revoke this authorization by notifying Coastal Childrens Clinic in writing. Federal law states that treatment, payment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law requires a statement that there is a potential for the protected health information released under this authorization may be subject to re-disclosure by the recipient.