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

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

WWW.COASTALCHILDRENS.COM

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

I hereby authorize (previous doctor's office): _____

Previous Doctor's Address: _____

Phone #: _____ Fax: _____

to disclose the following information: any and all medical reports, services and records, including:
(check all that apply)

- ☐ in-patient,
- ☐ out-patient,
- ☐ doctor's notes,
- ☐ correspondence,
- ☐ treatment,
- ☐ laboratory and pathological tests,
- ☐ examinations and analyses,
- ☐ surgical and non-surgical procedures,
- ☐ diagnosis, prognosis,
- ☐ history of billing or charges
- ✓ **Immunization & growth chart**

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.