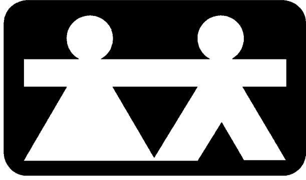

Coastal Children's Clinic

Excellence in Pediatrics For Over 50 Years!

New Bern	Havelock	Maysville
703 Newman Rd	218 Stonebridge Sq	1004 Jenkins Ave
New Bern, NC 28562	Havelock, NC 28532	Maysville, NC 28555
v(252)-633-2900	v(252)447-8100	v(910)743-2022
f(252)633-9609	f(252)447-1900	f(910)743-1283
Monday-Friday 8-5	Monday-Friday 8-5	Monday-Friday 8-5
Sat 8-12; Sun 12-4	WWW.COASTALCHILDRENS.COM	

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

I hereby authorize ____

to disclose the following information: any and all medical reports, services and records, including:

- ❑ in-patient,
- ❑ out-patient,
- ❑ doctor's notes,
- ❑ correspondence,
- ❑ treatment,
- ❑ laboratory and pathological tests,
- ❑ examinations and analyses,
- ❑ surgical and non-surgical procedures,
- ❑ diagnosis, prognosis,
- ❑ immunizations
- ❑ history of billing or charges

Said authorization is given for the following purpose or need:______________________________________

____

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

Coastal Childrens Clinic	Coastal Childrens Clinic	Coastal Childrens Clinic
703 Newman Road	218 Stonebridge Square	P.O. Box 160
New Bern, NC 28562	Havelock, NC 28532	Maysville, NC 28555

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 ________ and will expire without further notice or condition. (Date or Defined Event)

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. ___________.

____________________ ________________________________ __________________________

Chart # Patient's Name 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 redisclosure by the recipient.