HOLLY SPRINGS PEDIATRICS
106 Hyannis Drive
Holly Springs, NC 27540
(T) 919-249-4700
(F) 919-249-4701

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____
Address: _____
Daytime Phone (in the event we need to contact you): _____

Please release all medical records with immunizations: _____
Please release immunizations only: _____

I do ____ / **I do not** ____ authorize the release of information related to AIDS, HIV, psychiatric care and/or psychological assessment and treatment for alcohol/drug abuse.

Name of previous clinic: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Please mail or fax* Information to:
Holly Springs Pediatrics
106 Hyannis Drive
Holly Springs, NC 27540
Phone: 919-249-4700
Fax: 919-249-4701
*__PLEASE__ only fax if **25 or fewer** pages

I hereby authorize disclosure of health information for the above named patient. This authorization will automatically expire 18 months from date signed. I understand that I may cancel this request with written notification, but will not affect any information released prior to cancellation. Any documents released are no longer protected by Federal Law regulations.

Parent/Guardian Signature: _____ Date: _____

Printed Parent/Guardian Name: _____