Shifa Pediatric Clinic, PLLC.
Medical Record Release Form

Patient Information

_____ _____ _____/_____/_____
Patient Name Patient Date of Birth

_____
Address City State Zip

(_____)_____-_____ (_____)_____-_____ _____
Home Phone Cell Phone **Dates of Services From-To**

Information Requested

____All Records (includes all categories)
____Immunization Record
____Hospital Records
____Office Visits
____X-Ray Reports
____Lab Reports
____Other: _____

Purpose of Release

___Self
___Continued Medical Care
___Attorney Request
___Specialist Referral

Information To Be Released **To**:

Shifa Pediatric Clinic PLLC
1001 W Williams St, Suite 102,
Apex Medical Park, Apex, NC 27502
Phone: (919) 300 - SPC6 (7726), **Fax**: (919) 300 - 7688

Information To Be Released **From**: _____
_____
_____
_____

I understand that information in this health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency virus (HIV) and other communicable diseases, Behavioral Health Care and treatment related to drug or alcohol use; my signature authorizes the release of such information.

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2.

This authorization expires within 90 days from the date specified, unless I revoke this authorization earlier. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Our Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

I understand that Shifa Pediatric Clinic cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Shifa Pediatric Clinic may or may not protect this information once it has been disclosed to the recipient.

_____ _____
Signature of Parent/Legal Guardian Printed Name Date

_____ _____
Signature of Patient (If 18 years of age or older) Printed Name Date