

# Shifa Pediatric Clinic, PLLC.

## Medical Record Release Form

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### 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 **From:**

**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 **To:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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