Ashe Pediatrics

Sheila Driver PNP-BC, AE-C

PO Box 1499 303 East 2nd Street Suite A

West Jefferson, NC 28694

336-846-4KIDS (4543) Fax 336-846-PEDS (7337)

Medical Release Form for Requesting Records

Patient's Name _____ **Date of Birth** _____

Facility/Physician's office being asked for information

(name and address) _____

_____

_____

I, _____ authorize the above named facility to release

(Self, Parent, Legal Guardian name)

specified information concerning me to: name and address of facility or person to which disclosure is to be made to:

Ashe Pediatrics

_____ **Mail records to:** PO Box 1499 West Jefferson, NC 28694

_____ **Fax records to:** 336-846-PEDS (7337)

_____ **FedEx/UPS records to:** 303 2nd East Street Suite A, West Jefferson, NC 28694

This data shall include:

- ☐ Vaccine records
- ☐ Growth charts
- ☐ Complete records
- ☐ Lab data
- ☐ Inpatient records
- ☐ Outpatient records
- ☐ Consultations
- ☐ X-ray reports
- ☐ Labor & delivery, newborn record with labs including newborn screening & hearing
- ☐ ER records with labs and x-ray from _____
- ☐ Hospital admission note/H & P and Discharge Summary/Note records
- ☐ Other _____

(extent and nature of data to be disclosed)

The purpose of releasing this data shall be: medical follow-up, insurance, personal, legal,

Circle: Transfer of care Continuation of care Follow-up visit Consultation

other_____.

The above information will be released only to the specified facility. The information that is released is subject to redisclosure and is no longer protected by the privacy regulations. I understand that I may revoke this authorization at any time by submitting a written notice of revocation of this authorization. This consent will expire 365 days from the date of signature.

Signed: _____ _____

(specify relationship if other than patient: Parent, Legal Guardian, or Administrator of Estate)

Date: _____

Witness: _____

12/27/15