Starks Pediatrics

Authorization of Release of Protected Health Information

Patient Information	_____ Patient Name _____ Address _____ City State Zip	_____/_____/_____ Patient Date of Birth (_____)_____-_____ Phone Number _____ Dates of Services From-To
Information Requested	____All Records(includes all categories) ____Immunization Record ____Hospital Records ____Office Visits ____X-Ray Reports ____Lab Reports ____Other: _____ Please Specify	**Purpose of Release** ___Self ___Continued Medical Care ___Attorney Request ___Specialist Referral

Information To Be Released **TO**:			Information To Be Released **FROM**:	
Physician/Hospital	Starks Pediatrics at Mallard Creek		Physician/Hospital	
Street	2315 W. Arbors Dr. Suite 115		Street	
City, State, ZIP	Charlotte, NC 28262		City, State, ZIP	
Phone	(704) 717-2826		Phone	
Fax	(704) 971-5014		Fax	

I understand that information in my 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 Starks Pediatrics cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Starks Pediatrics 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