Pediatric Neurology of North Carolina, PA

Formerly located at 206 Towne Village Dr. Cary, NC 27513 & 508 Sandhurst Drive Fayetteville, NC 28304

RECORDS REQUEST (FROM PNNC)

FOR ENTIRE MEDICAL RECORD

Send this form as an attachment to pediatricneurologyofnc@gmail.com and make the payment of $10.86 via PayPal.

Patient Name: _____DOB_____

Last 4 digits of SOCIAL SECURITY#_____ Mailing ADDRESS_____
(Street, city, state, zip)

Phone#_____ email: _____
(in case we need to contact you before we can send out the records)

RECORDS TO BE RELEASED TO: _____

At (address) (same as above or fill in): _____
OR if you prefer and initial the following line: via email attachment
(Initials) _____ I prefer and give permission for these records to be sent by email attachment to the email address above.
(Your choice – but only one of the two options)

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to it's release.
Check one: __Yes __No _____Initials
I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.
Check one: __Yes __No _____Initials

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing. Unless revoked, this authorization will expire one year from the date the release is signed.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I authorize Reliable Medical Records on behalf of Pediatric Neurology of NC, PA to use and disclose the protected health information specified above.

Signature: _____Date: _____

Authority to Sign if not patient:(guardian / parent) _____

[If you are not sure that your signature is on file with PNNC, please provide proof such as a photo ID or a signed Insurance Card listing patient by name and you (the signer) by name.]

Submit **this form** as an attachment to pediatricneurologyofnc@gmail.com and make the payment of $10.86 via PayPal (click on the PayPal button on the website where you got this form).

[For staff use]
Identity of Requestor Verified via: __Photo ID __Matching Signature __Other, specify
Verified By: _____
Date: received ____ sent: _____