CENTER FOR pediatric and adolescent MEDICINE, PA

CPAM CHART # _____

WE IMMUNIZE
FOLLOWING THE CDC CHILDHOOD AND ADOLESCENT IMMUNIZATION SCHEDULE

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AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

I authorize the Center for Pediatric and Adolescent Medicine to obtain the record of care on the patient listed below through the release of protected health information from the following entity/medical office:

_____
Entity Name/Medical Office to request the Transfer of Records from *(Please Print)*

_____ _____
Office Address Office Phone

_____ _____
City, State, Zip Code Office Facsimile

This authorization permits the entity/medical office listed above to release and send (within 30 days of reciept of this request) the listed patient's protected health information to the following entity/medical office:

Center for Pediatric and Adolescent Medicine
Attn: Privacy Administrator
136 Gateway Boulevard – Suite A
Mooresville, NC 28117-5608

This authorization permits the Center for Pediatric and Adolescent Medicine to request, obtain and use the following protected health information about the patient listed below. Check the appropriate box or specifically describe the information to be obtained and/or disclosed, such as date(s) of service, type of service, level of detail to be released, origin of information, etc. as needed.

☐Entire Record ☐Immunization Records ☐Other *(Please Describe)*: _____

_____

The purpose the information will be used or disclosed:

☐Patient Request ☐Physician Transfer ☐Moving ☐Other *(Please Describe)*: _____

I have the right to refuse to sign this authorization. The Center for Pediatric and Adolescent Medicine may not condition treatment on whether authorization is obtained unless the provided service is for the sole purpose of creating information for a third party. When the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by federal or North Carolina laws. I have the right to revoke this authorization, except to the extent that the practice has acted in reliance upon it, by obtaining and submitting the Revocation Form.

This authorization shall remain in effect until _____/_____/_____ *(Specified Date)* or shall expire one (1) year from the date of signing unless a revocation form has been properly submitted.

Required Information and Signature

_____ _____
Name of Patient *(Please Print or Type)* Patient Date of Birth

_____
Signature of Patient or Patient Representative

_____ _____
Name of Patient Representative and Relationship to Patient *(Please Print or Type)* Date of Request

**** I UNDERSTAND THE ENTITY/MEDICAL OFFICE RELEASING THE PROTECTED HEALTH INFORMATION MAY ELECT TO CHARGE ME A RESONALBLE ADMINISTRATIVE FEE TO COVER COST OF TIME AND COPYING THE RELEASE REQUEST. SOME ENTITIES/OFFICES UTILIZE THIRD PARTY VENDORS FOR THIS COPY SERVICE AND MAY BILL ME DIRECTLY.***