Carolina Kids Pediatric Associates, PLLC

2605 Blue Ridge Road Suite 100 - Raleigh, N.C. 27607 – Phone: (919) 881-9009 – Fax: (919) 881-8463

Please note: To process your request in a timely manner, this form must be complete and signed. Fees may apply, but will not exceed $20.00 per child. Requests will be processed once any applicable fees are paid.

Save time and money by using our patient portal to access your child's records!

If your child is a current patient under the age of 18, most of their records may be available to you through our patient portal. If you wish to use the portal to access records, you do not need to complete this form.

Parent/Patient/Guardian Name: _____ **Phone: (___)**_____

Full Mailing Address : _____
(If moving, please provide a forwarding address)

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

Please send: ___ Last Well Exam, Growth, Vaccines, Problem List, Current Med List (No charge)
___ All records for the past 2 years ___ Office Visits ___ Specialist Reports ___ Labs & Imaging
___ Other, please specify: _____

I would like to (select one): ___ **Pick up records** (We will notify you when they are ready)
___ **Have records mailed to:**
Name/Business: _____
Address: _____
City/State/Zip: _____
Phone: _____

Would you like your records on disk or on paper? _____
(Due to HIPAA constraints, we unable to email records. If your child is a current patient under the age of 18, recent records are available on the patient portal.)

I authorize Carolina Kids Pediatric Assoc. to disclose my protected health information as described above. My protected health information will be disclosed for the following purpose: _____ (i.e. moving, transfer, personal copy)
I UNDERSTAND that if my child's protected information is disclosed to a person or entity that is not required to comply with federal privacy protection regulations, that information would no longer be protected. Unless revoked, this authorization will expire one year from the date it was signed. I UNDERSTAND that I have the right to revoke this authorization at any time and that a copy of this form will be available upon request.

I have read the above. By signing, I acknowledge that I understand and agree to the information provided to me.

Print Name: _____ **Signature:** _____

Relationship to Patient: **Self** **Parent** **Guardian** **Date:** _____
(circle one)

Please do not write below the line. The space is for office use only.