**Carolina Kids Pediatric Associates, PLLC**

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

**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

\_\_\_ All records for the past 2 years \_\_\_ Office Visits \_\_\_ Specialist Reports \_\_\_ Labs & Imaging \_\_\_ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please send requested records to:**

**Carolina Kids Pediatric Associates, PLLC**

**2605 Blue Ridge Rd, Ste 100**

**Raleigh, NC 27607**

**Ph(919) 881-9009**

**Fax(919) 881-8463**

**Attn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release my records to Carolina Kids Pediatric Assoc. as described above. My protected health information will be disclosed for the following for continuation of care

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.