AUTHORIZATION TO RECEIVE MEDICAL RECORDS

The records are coming FROM:

Provider/Facility: ______________________________ Phone: ____________________

Street Address: ______________________________ City: ____________ State: ______

Fax number: ____________________ Email: ______________________________

I authorize the above practice to release the following medical records for my child:

Child's Name: ______________________________ Phone: ____________________

Street Address: ______________________________ City: ____________ State: ______

DOB: ______________ SSN: __________________ Medical Record: ______________

Treatment Dates: (from) ____________________ (to) ____________________

Please transfer all medical records, including immunizations, well-child visits, and sick visits for all dates of service.

The purpose of this request is for continued patient care. Consent expires in 90 days.

Please fax or email this request to:

Fax: 252.606.4325

Email: RORTIZ@KIDMEDNC.COM

Patient Representative: ____________________ **Relationship:** ______________

Signature: ______________________________ **Date:** ____________________

1165 CEDAR POINT BLVD. SUITE F CEDAR POINT, NC 28584 252.364.4690 WWW.KIDMEDNC.COM