CareNow PEDIATRICS

6402, McCrimmon Parkway, Suite#300,
Morrisville, NC 27560
919-678-3005

Medical Release of Information Form
Transferring In

THIS AUTHORIZATION WILL EXPIRE TWELVE (12) MONTHS FROM THE DATE SIGNED.

Patient Name: _____ Date of Birth: _____

I request and authorize _____
[Name of physician and clinic/practice]

Address/City/State/Zip (of office listed above) _____

Phone: _____ Fax: _____

To release the medical record of the above-named patient to:
CareNow Pediatrics
6402, McCrimmon Parkway, Suite#300,
Morrisville, NC. Zip-Code 27560
Fax # 919-584-8154

This request and authorization applies to: *Please initial next to the appropriate line. (Please initial only one)*

_____ ALL HEALTHCARE INFORMATION **including** immunization records, well and sick visits, labs, x-ray reports.

_____ MOST RECENT HEALTHCARE INFORMATION **including** immunization records, last physical exam with labs.

PLEASE ALLOW TEN (10) TO FOURTEEN (14) BUSINESS DAYS TO PROCESS YOUR REQUEST.

Please initial the following acknowledgement:

_____ I understand I have the right to revoke this authorization by providing a written request to do so to the above-named physician or organization. I understand that the revocation will not apply to information that has already been released.

_____ _____ _____
[*Signature of patient or authorized representative*] [*Date*] [*Relationship to patient*]