**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 $30.00 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, **I would like to (select one):**

 Problem List, Current Med List ***(No charge)*** **\_\_\_ Pick up records** (We will notify you when they are ready)

\_\_\_ All records for the past 2 years **\_\_\_ Have records mailed to:**

\_\_\_ Office Visits **Name/Business: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_ Specialist Reports **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_ Labs & Imaging **City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fees to process this request:**

* **NO CHARGE:** Immunizations, last well check, growth charts, medication list, and problem list
* **$10 per child:** No charge records and additional pages up to 30 pages.
* **$20 per child:** 31+ pages (Most common fee when “All Records” are requested)

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.**)**

If the requestor is asking for records ***on both paper and disc***, and additional fee of **$10** will be assessed.

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.**

**If the patient is 18 years old or older, the patient must sign the release.**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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