3721 Lynn Road, Suite 104 Raleigh, NC 27613 Office: 919 825-3600 Fax: 984 200-6001

Authorization to Use/Release/Disclose Health Information

Please Note: Mack Pediatrics cannot offer interpretation or advice regarding the information contained in the requested medical record until the record has been received and reviewed. It can take 30 business days for a facility to prepare and release records.

I hereby authorize the use, release and/or disclosure of my health information as described below.
Patient Name:_____ Date of Birth:____/____/_____

Specialist/Organization Providing the Information:	Organization Receiving the Information:
Name :_____	Mack Pediatrics
Street:_____	3721 Lynn Road, Suite 104
City/State/Zipcode: _____	Raleigh, NC 27613
Phone_____Fax_____	Phone 919-825-3600 Fax 984-200-6001

I authorize this information to be sent to Mack Pediatrics at the above address:
X Specified medical record(s):_____

- I have the right to revoke this Authorization, in writing, at any time by notifying Mack Pediatrics. Such revocation will not apply to information that has already been disclosed in reliance of this Authorization.
- I have the right not to sign this Authorization. Mack Pediatrics will not condition treatments, payment for services or enrollment or eligibility for benefit on whether I sign this Authorization.
- The Organization Providing the Information may deny in writing your request to inspect and/or copy your records in limited circumstances. You may request a review of the denial in writing. Another licensed health care professional, chosen by them, will conduct a review of the denial.
- I have read and understand this Authorization, have had the opportunity to have my questions answered, have signed this Authorization freely and, if requested have received a copy of it.
- This Authorization expires one year after the date below unless otherwise specified:_____

Signature: _____Name:_____ Date ____/____/_____
Relationship to Child:_____
