

Request for Records Release

➤ Please select the box (☑) that describes what type of transfer of records is needed:

I authorize:

 Facility Name

 Facility Address

 Facility Address

 Facility Address

➤ to release medical records to ◀
 the Physicians of
**RALEIGH CHILDREN
 & ADOLESCENTS MEDICINE**
 2800 Blue Ridge Road, Suite 401
 Raleigh, NC 27607
 Tel 919-781-7490 Fax 919-783-0903

I authorize:

the Physicians of
**RALEIGH CHILDREN
 & ADOLESCENTS MEDICINE**

➤ to release medical records to ◀

 Facility Name

 Facility Address

 Facility Address

 Facility Address

Please list each child's full name...	...and date of birth

➤ I give authorization for release of medical records for each child listed above (please sign):

Parent / Guardian Signature	Relationship to above	Date
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➤ Please complete (☑):

Purpose for Release of Records:

- Medical follow-up with a specialist
- Legal
- Transfer to another practice
- Other (please list why):

If the purpose is a transfer, please list why:

- Move
- Insurance change (What Insurance?)
- Other: _____

➤ The cost for a summary of medical records is \$20 per child. Please allow 2-3 weeks to process this request.