AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________

Previous Name: ______________________ UNC MR # ______________

I request and authorize **UNC Healthcare** to release healthcare information of the patient named above to:

Name: **Carolina Developmental Pediatrics**

Address: 1001 W. Williams St. Ste 104

City: Apex State: NC Zip Code: 27502

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________

____

☐ All healthcare information

☐ Other: ____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Parent Signature: ______________________ Date Signed: ______________

Parent Name (Printed) ____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

Fax completed form to :

919-362-5409