CHILDREN'S MEDICAL GROUP OF SALISBURY, P.A.
217 PHILLIP MORRIS DRIVE
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MEDICAL RECORD RELEASE AUTHORIZATION FORM

The Law requires the following information before we can release the medical records of your child.

Patient Name: ____ Date of Birth:__________________________

MUST CHECK ONE

___ I Authorize **Children's Medical Group of Salisbury** to **obtain ALL** my Protected Health Information from:

Name____

Specialist ____

Address____

City ____ State ________________ Zip________________

Phone: _____________________________________ Fax: _____________________________________

OR

___ I Authorize **Children's Medical Group of Salisbury** to **release** my Protected Health Information to the following person(s) / organization(s):

Name____

Address____

City ____ State ________________ Zip________________

Phone: _____________________________________ Fax: _____________________________________

Please Check Reason for Release:

__ Moving (New Address) ____

__ Insurance Change

__ Transition to Adult Physician

__ Unhappy with staff/provider

__ Personal Use

__ Legal Issues

__Other (please specify) ____

Please Note: We do not copy information generated by other physician's offices.
There is a $20.00 fee for a copy of records and a $5.00 mailing fee.
This Authorization: Will expire in 12 months.
May be revoked in writing, but prior disclosures will not be affected.

____ (Signature)

_______________________________________ (Date)

____ (Relationship to Patient)

_______________________________________ (Contact phone #)