Donna A. Page, M.D
Calvin O. Tomkins, M.D.
Susan R. Cohen, M.D.
Peter D. Leimena, M.D.
Leigh M. Dodson, M.D.
Eleanor A. Martin, M.D.

2 Medical Park Drive, Suite 1000
Asheville, NC 28803
Phone: 828-254-5326 Fax: 828-251-5954
www.ashevillepediatrics.com

Authorization for Disclosure of Health Information
(Autorización para utilizar o divulgar su Información de Salud)

1. I hereby authorize the disclosure of the following information from the health records of:
   (Autorizo la divulgación de la siguiente información de los registros de salud de):

Patient's Name/(Nombre del Paciente): ____________________________________DOB/*(Fecha de nacimiento)*:________

Address/*(Direccion)*:____ Phone #: ________________________

____

Covering the period(s) of health care from ____________________________ to _____________________________

2. This information will be disclosed

To:

____
Name of Office/Guardian

____
Address

____
City State Zip

____________________/____________________
Phone # Fax #

From:

____
Name of Office

____
Address

____
City State Zip

____________________/____________________
Phone # Fax #

For the purpose of ____

3. Information to be disclosed:

____ History & Physical Examination/ Well-Child Visits
____ Consultation Reports
____ X-ray Reports
____ Immunizations
____ Discharge Summary/ Specialists Notes
____ Problem & Medicine Lists
____ Laboratory Tests
____ Other (Please Specify):_________________________

I understand that this will include information relating to (check if applicable):
____ Acquired Immunodeficiency Syndrome (AIDS)
____ Human Immunodeficiency Virus (HIV) infection
____ Behavioral health service/psychiatric care
____ Treatment for alcohol and/or drug abuse

4. I understand this authorization may be revoked in writing at any time except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition.

5. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Parent/Guardian Name: ____

Signature: ____ **Date:** ______________

Relationship to Patient: ____

Signature of Witness: ____ Date: ______________

******PLEASE SEE OTHER SIDE FOR MEDICAL RECORDS FEES*******

FEES FOR MEDICAL RECORDS

If you are requesting Medical Records please be advised that there will be a charge as follows.

Up to 25 pages- *$**15 Flat fee***

Pages 25 and over $0.10 per page

Medical Records transferred to another office – ***No Charge***

Medical records will not be released until fee is collected

Number of Pages	Fee	Amount Paid	Staff Initials