Carteret Clinic for Adolescents and Children
3510 John Platt Drive • Morehead City, NC 28557
(252) 726-0511 • Fax: (252) 726-7441
www.carteretclinic.com

FOR OFFICE USE ONLY
rec'd by _____ / _____
completed by _____ / _____

REQUEST FOR RELEASE AND DISCLOSURE OF MEDICAL RECORDS (PROTECTED HEALTH INFORMATION)

Name of individual whose protected health information is to be disclosed:

Patient Full Name: _____ Date of Birth: _____

Phone Number: _____ Chart Number: _____

Patient Address: _____

City, State, Zip: _____

Description of information to be disclosed from treatment provided by Carteret Children's Clinic:

❑ medical records for the period **(NOT to include mental health records)** _____ to _____

or ❑ the following specific portions of the medical record for the period **(NOT to include mental health records)** from _____ to _____:

❑ immunization records
- ❑ history and physicals
- ❑ lab results, x-rays, diagnostic test results
- ❑ other _____
- ❑ educational testing results (CCC only)
- ❑ developmental/psychological information (CCC only)
- ❑ medication sheet, medication information
- ❑ CCA comprehensive clinical assessment

You have the right to exclude information about substance abuse, and HIV/AIDS-related information. This information is protected by Federal confidentiality rules (42 CFR part 2 and 130-A143). The rules prohibit us from making any further disclosure of information unless further disclosure is expressly permitted by your written consent.

YES, DISCLOSE THIS INFORMATION: I give consent to release information about **HIV/AIDS.**

Signature: _____ Date: _____

YES, DISCLOSE THIS INFORMATION: I give consent to release information about **substance abuse.**

Signature: _____ Date: _____

Name of facility disclosing information:
I hereby authorize the following organization/person to **release** protected health information:

Name: _____

Address: _____

City, State Zip: _____

Phone Number: _____

Name of facility/person to receive protected health information:

Name: _____

Address: _____

City, State Zip: _____

Phone Number: _____

Purpose of Disclosure
- ❑ continuing medical care
- ❑ referral
- ❑ legal proceedings (name of attorney)
- ❑ other _____
- ❑ personal use
- ❑ insurance request

I understand that I may **revoke** this release at any time, in writing, but the request shall remain valid until revoked or upon the **expiration** of 365 days. The revocation may not be effective to the extent that action has already been taken on this authorization. I understand that Carteret Children's Clinic assumes no responsibility for the use or misuse by others of my health information and I release them from all legal liability that may arise from this authorization.

Parent/legal guardian signature: _____ Date: _____

Please Print: _____ Relationship to Patient: _____

Witness: _____ Date: _____