



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 _____ / ____

Welcome

Tell Us About Your Child

Today's Date: _____ Home Phone #: (____) _____ Child's SS #: _____ Race: _____
 Child's Name: _____ Child's Birthdate: ____ / ____ / ____ Child's Age: ____
Last First MI
 Nickname: _____ Male Female School _____ Grade: _____
 Child's Home Address: _____
Street City State Zip

Your Name: _____ Relation to Patient: _____
 Do you have legal custody of this child? Yes No Shared Is the child in a foster home? Yes No
 Whom may we thank for referring you? _____ Other siblings seen by us: _____

Emergency Contact (Neighbor or relative not living with you)

Name: _____ Relation to Patient: _____ Work Ph. (____) _____ Home Ph. (____) _____
 Address: _____
Street City State Zip

Previous Physician

Name _____ Address _____ Phone #: (____) _____

Parent's Marital Status: Married Divorced Separated Widowed Remarried Single

Mother: Step Mother Guardian Birthdate: ____ / ____ / ____ Home Ph. (____) _____ Work Ph. (____) _____
 Name: _____ Social Security #: _____
 Address: _____
Street City State Zip
 Employer: _____ Length of Employment: _____

Father: Step Father Guardian Birthdate: ____ / ____ / ____ Home Ph. (____) _____ Work Ph. (____) _____
 Name: _____ Social Security #: _____
 Address: _____
Street City State Zip
 Employer: _____ Length of Employment: _____

Parents' Information

Child's Family History

	Age, if Living	Age at Death & Cause of Death	Condition	Yes	No	Family Member(s)
Mother	_____	_____	Rheumatic Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	_____	_____	Muscle Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Siblings (circle one)	Age, if Living	Age at Death & Cause of Death	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Male / Female	_____	_____	Eye or Ear Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Male / Female	_____	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Male / Female	_____	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Male / Female	_____	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
			Heart Disease/Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
			Anemia/Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
			High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
			Kidney Disease/Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
			Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
			Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	_____
			Seizures/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____
			Mental Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
			Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
			HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
			Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family Medical problems

Please identify any medical problems blood relatives have or ever have had.

Condition	Yes	No	Family Member(s)
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genetic Defects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone/Joint Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____

Child's Health History

Has your child ever had:	Yes	No	Nose and throat	Yes	No	Musculoskeletal system	Yes	No	General	Yes	No
Measles (10 day)	<input type="checkbox"/>	<input type="checkbox"/>	Frequent sore throats	<input type="checkbox"/>	<input type="checkbox"/>	Painful or swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	Has your child ever:	<input type="checkbox"/>	<input type="checkbox"/>
Rubella (3 day measles)	<input type="checkbox"/>	<input type="checkbox"/>	Persistent hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Sprains, dislocations, or broken bones	<input type="checkbox"/>	<input type="checkbox"/>	Had excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Posture problems	<input type="checkbox"/>	<input type="checkbox"/>	Had marked increase or decrease in appetite	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	Frequent stuffed up nose	<input type="checkbox"/>	<input type="checkbox"/>	Muscle coordination or strength problems	<input type="checkbox"/>	<input type="checkbox"/>	Had unusual sensitivity to heat or cold	<input type="checkbox"/>	<input type="checkbox"/>
Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>	Frequent tonsil infections	<input type="checkbox"/>	<input type="checkbox"/>	Skin			Eaten paint, dirt or plaster	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to breathe through his (her) mouth	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/skin problems	<input type="checkbox"/>	<input type="checkbox"/>	Been persistently tired	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (liver disorders)	<input type="checkbox"/>	<input type="checkbox"/>	Lungs/Asthma			Slow healing bruises	<input type="checkbox"/>	<input type="checkbox"/>	Had unusually slow healing scrapes, cuts or wounds	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis or chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Persistent rashes	<input type="checkbox"/>	<input type="checkbox"/>	Had a recurrent fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to wheeze	<input type="checkbox"/>	<input type="checkbox"/>	Digestive system			Within the past six months, has your child:		
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Repeated coughing spells	<input type="checkbox"/>	<input type="checkbox"/>	Frequent stomach aches	<input type="checkbox"/>	<input type="checkbox"/>	Had frequent nightmares	<input type="checkbox"/>	<input type="checkbox"/>
Anemia/blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart			Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Been unusually nervous or high strung	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty talking	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequent constipation	<input type="checkbox"/>	<input type="checkbox"/>	Had extreme mood swings	<input type="checkbox"/>	<input type="checkbox"/>
Stuttering	<input type="checkbox"/>	<input type="checkbox"/>	To be propped up in bed to breathe comfortably	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Been unusually disobedient	<input type="checkbox"/>	<input type="checkbox"/>
Eyes			To squat down to breathe when playing	<input type="checkbox"/>	<input type="checkbox"/>	Worms	<input type="checkbox"/>	<input type="checkbox"/>	Been having problems at school or with friends	<input type="checkbox"/>	<input type="checkbox"/>
Crossed or wandering eyes	<input type="checkbox"/>	<input type="checkbox"/>	Nervous System			Bloody or very dark stools	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Special food restrictions	<input type="checkbox"/>	<input type="checkbox"/>	Describe any problems _____		
Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>	Periods of confusion or disorientation	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary system			_____		
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, seizures	<input type="checkbox"/>	<input type="checkbox"/>	A urination problem	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Ears			Tremors ("the shakes")	<input type="checkbox"/>	<input type="checkbox"/>	Painful, burning urination	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty walking, balancing or handling objects	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>				Unusual urine odor	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Mouth						Persistent diaper rash	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Been to a dentist	<input type="checkbox"/>	<input type="checkbox"/>				Bed-wetting problems	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Date of last visit _____						A discharge from vagina or penis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>							_____		
Sores in mouth/gums	<input type="checkbox"/>	<input type="checkbox"/>							_____		

PREGNANCY & BIRTH

Is child adopted? Yes No Child's age at adoption _____ Mother's age at pregnancy? _____

Any illness during pregnancy? Yes No Describe any illnesses: _____

Medications taken during pregnancy: _____

Smoking / alcohol / street drugs / during pregnancy? (specify) _____

Was the baby early / late / on time? _____ Type of delivery: C-Section / vaginal? _____

Baby's birth weight _____ Length _____ Complications? _____

Problems with baby at birth? breathing / jaundice / other? _____

DEVELOPMENT & BEHAVIOR

Please indicate age at which this child:

Sat alone _____ Walked _____ Used sentences _____ Toilet trained _____ Bicycled _____

Development compared to other children? _____

Grade in school? _____ Problems in school? _____

Getting along with other children? _____ Behavior problems? _____

Bad habits? _____ Bedwetting? _____

Nail biting? _____ Trouble sleeping? _____

Hobbies (sports - social activities)? _____ Use of street or illegal drugs? _____

FEEDING & NUTRITION

Food Allergies _____ Appetite usually good? _____

Colic or feeding problems during the first 3 months? _____ Breast fed? _____ Number of months breast fed? _____

Formula? _____ Brand _____ City or well water _____

Vitamins? _____ Brand _____ Taking fluoride? _____

Special Diet? _____

PAST MEDICAL HISTORY

Medications taken on a regular basis? _____

Immunizations up to date? _____ Do you have a shot record? _____ (If no, please request from previous doctor.)

Hospitalizations (when / where / why?) _____

Serious injuries (when / where / what?) _____

Is child on nebulizer? _____ Is child on monitor? _____

ALLERGY ALERT

Please list all allergies, include the substance and your child's reaction to it: _____

Parent Signature: _____ Date: _____

Print Name: _____ Nurse Signature: _____ Date: _____



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FAMILY INFORMATION SHEET

CHILD BEING SEEN TODAY (if 18 years old or older, please list your phone #)

Child's Full Name: _____
First Middle Last Suffix Phone #

Child's Mailing Address: _____
Street City / State / Zip

Date of Birth: _____ Social Sec. No.: _____ Gender: Male / Female

Ethnicity: Non-Hispanic / Hispanic / Unknown **Race:** Amer. Indian or Eskimo / Asian / Black / Hawaiian or Pac Isl / White **Primary Language:** _____

Lives with: Both Natural Parents Mother Father Other (step- or grand parents, etc) _____

Biological Father Name _____ Biological Mother Name _____

Billing statements will be sent to Custodial Parent at above address unless otherwise specified and agreed upon _____

Primary Insurance Co.: _____ Secondary Insurance Co.: _____

Father / Legal Guardian Name: _____ Mother / Legal Guardian Name: _____

Social Sec. No.: _____ Soc. Sec. No.: _____

Date of Birth: _____ Date of Birth: _____

Mailing Address: _____ Mailing Address: _____

Physical Address: _____ Physical Address: _____

City: State: Zip: _____ City: State: Zip: _____

Phone (H): _____ (W): _____ Phone (H): _____ (W): _____

Mobile: _____ (other) _____ Mobile: _____ (other) _____

E-Mail: _____ E-Mail: _____

Employer / Occupation: _____ Employer / Occupation: _____

Please list any step parents or others involved in this child's care

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please complete this section if there is a court ordered custody agreement. We will need a copy of this documentation.

If parents are separated, divorced or not married, who has custody? FATHER / MOTHER / JOINT / OTHER _____

Are there any **LEGAL** restrictions for either parent that would keep them from consenting to medical treatment for child? YES or NO

(If yes please explain) _____

Emergency Contacts (local and NOT a parent)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Signature: _____ Relationship to patient: _____

Print Name: _____ Date: _____



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FAMILY INFORMATION SHEET Part 2 Other Children Living in Same Household

OTHER CHILD LIVING IN SAME HOUSEHOLD

Child's Full Name: _____
First Middle Last Suffix

Date of Birth: _____ Social Sec. No.: _____ Gender: Male / Female

Ethnicity: Non-Hispanic / Hispanic / Unknown **Race:** Amer. Indian or Eskimo / Asian / Black / Hawaiian or Pac Isl / White **Primary Language:** _____

Lives with: Both Natural Parents Mother Father Other (step- or grand parents, etc) _____

Biological Father Name: _____ Biological Mother Name: _____

Billing statements will be sent to Custodial Parent at above address unless otherwise specified and agreed upon _____

Primary Insurance Co.: _____ Secondary Insurance Co.: _____

OTHER CHILD LIVING IN SAME HOUSEHOLD

Child's Full Name: _____
First Middle Last Suffix

Date of Birth: _____ Social Sec. No.: _____ Gender: Male / Female

Ethnicity: Non-Hispanic / Hispanic / Unknown **Race:** Amer. Indian or Eskimo / Asian / Black / Hawaiian or Pac Isl / White **Primary Language:** _____

Lives with: Both Natural Parents Mother Father Other (step- or grand parents, etc) _____

Biological Father Name: _____ Biological Mother Name: _____

Billing statements will be sent to Custodial Parent at above address unless otherwise specified and agreed upon _____

Primary Insurance Co.: _____ Secondary Insurance Co.: _____

OTHER CHILD LIVING IN SAME HOUSEHOLD

Child's Full Name: _____
First Middle Last Suffix

Date of Birth: _____ Social Sec. No.: _____ Gender: Male / Female

Ethnicity: Non-Hispanic / Hispanic / Unknown **Race:** Amer. Indian or Eskimo / Asian / Black / Hawaiian or Pac Isl / White **Primary Language:** _____

Lives with: Both Natural Parents Mother Father Other (step- or grand parents, etc) _____

Biological Father Name: _____ Biological Mother Name: _____

Billing statements will be sent to Custodial Parent at above address unless otherwise specified and agreed upon _____

Primary Insurance Co.: _____ Secondary Insurance Co.: _____

Signature: _____

Relationship to patient: _____

Print Name: _____

Date: _____



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FINANCIAL POLICY AND AGREEMENT TO PAY FOR TREATMENT

We are pleased that you have chosen us to provide health care for your child. In order to avoid any misunderstanding, we ask that you carefully read and sign this financial statement. If you have any questions, please do not hesitate to ask one of our staff members.

1. The person who brings the child to our office is expected to pay for that day's visit. We accept cash, personal check, and Mastercard / Visa. All copayments are required to be paid at the time of service. For patients not covered by insurance (self pay) we offer a **25% discount** if the charges are **paid in full** at the time of service. There are times when it is not possible to pay in full at the time of each visit, and in such cases, you must speak with the account manager to discuss payment options.
2. We are contracted with Blue Cross/Blue Shield, Medcost, Cigna, Aetna, United Healthcare and Atlantic Integrated Health. We are in network with Tricare and are Tricare Prime managers for those patients assigned to our clinic. Mental Health services vary between insurance companies, so please check with your insurance company for detailed information regarding what is covered under your policy. We also accept patients covered by NC Medicaid and NC Health Choice. We will file your insurance claims under these carriers as well as most other major insurance carriers as a courtesy. You must verify your insurance coverage at every visit. We will be happy to assist you in filing your own insurance claims with your carrier if necessary.
3. If your child is covered by Medicaid, you must present the card to the receptionist prior to each visit to our office. Without proof of coverage, we cannot perform services under the Medicaid program, and you will be responsible for payment of all charges. If the child is covered by other insurance in addition to Medicaid, it is VERY important that we get this information. If another physician is listed as the Carolina Access provider, they are required to authorize any services we provide at our clinic. Our insurance department will discuss any questions you may have regarding insurance coverage and our policies.
4. It is important that you understand that our financial relationship is with you, not your insurance company. For certain carriers, we file claims as a courtesy, however, the parent or responsible party is ultimately responsible for the bill. It is always your responsibility to understand the coverage your insurance program provides and its referral process. It is your responsibility to secure proper authorization if your plan requires prior approval to make an appointment with us. Visitors should be especially aware of this if they are members of an HMO or preferred care plan. If your insurer refuses to pay for services or you do not have authorization for our services, you are responsible for non-covered charges.
5. The person who brings the child to the office is expected to make a payment on that day of service. However, when a relative or other caretaker brings the child, the charges can be applied to that child's account if previous arrangements have been made and the account is in good standing. In cases where the parents are separated or divorced, the parent bringing the child to our office is responsible for payment. Only one parent can be billed, therefore both parents have the responsibility to communicate with each other to ensure that their child's account does not become delinquent.
6. Collection procedures: Established accounts will receive monthly statements reflecting the balance due on the account after insurance has been filed and all insurance payments have been received. Should no payment be received on the account for 60 days, additional mail and phone reminders will be made in an attempt to collect the debt. Our policy is to help those with outstanding balances understand their account and reach an agreement on payment options. After 90 days of nonpayment or if a payment agreement is breached, an unpaid account may be turned over to an outside collection agency with an additional 35% fee to cover costs involved in the collection process.
7. A \$25 charge is made for all checks returned for non-sufficient funds.
8. Overpayments on your account will be refunded within 90 days of overpayment, or upon request.

I have read the above financial policy of Carteret Clinic for Adolescents and Children and understand completely my responsibilities under this policy. I agree to pay all charges submitted by this office during the course of treatment.

Responsible party (please print): _____ Signature: _____

Patient(s) Name: _____

Date(s) of Birth: _____

Today's Date: _____



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AUTHORIZATIONS

Please read each authorization section carefully and sign at the bottom. If you have any questions, please ask for clarification. One must be signed for EACH patient. The following authorizations shall remain in effect until specifically revoked in writing.

Full Name of Patient (please print): _____ Date of Birth _____

Certification of Authority to Consent

I certify that I am the Patient or the legal guardian of the Patient and, if the Patient is a minor, I certify that I am a parent of the minor Patient, or if living separate and apart or divorced, the custodial parent or authorized non-custodial parent of the minor Patient (collectively the "Patient or Legal Guardian") and that I have full authority to give legal and valid consent to the following for the Patient.

Consent for Treatment

I, being the parent or guardian of the Patient, who is a minor child, do hereby request and authorize the staff of Carteret Children's Clinic to perform any and all necessary services for the Patient, including but not limited to immunizations, labwork, and the administration of anesthetics which are deemed advisable by the provider, whether or not I am present at the actual appointment when the treatment is rendered. Any photos taken of the patient will be used for purposes of identification in the medical record. I understand that I have the right to refuse treatment without threat or termination of services except as outlined in the statute **GS122C-57(d)**. Consent for treatment may be withdrawn at any time, in writing.

Release and Statement to Permit Payment of Private Insurance Benefits to Provider

The undersigned Patient or Legal Guardian hereby authorizes Carteret Children's Clinic, its agents and employees to release and disclose all or any part of the Patient's medical records to any entity which is, or may be, liable for all or part of the provider's charges for services rendered or items supplied to the Patient. The undersigned Patient or Legal Guardian authorizes the release and disclosure of any and all medical records to any other entity, including, but not limited to, referring physicians, hospitals, or other health care providers which may be of assistance, in the opinion of this office, in providing for the treatment of the Patient.

The undersigned Patient or Legal Guardian authorizes the release of records necessary to assist in the reimbursement of benefits to which the Patient or Legal Guardian may be entitled in connection with services rendered or items supplied to the Patient by Carteret Children's Clinic and authorizes this office and/or its employees to release, via fax, electronic or paper format, medical records which are needed in order to provide the Patient with the most appropriate medical care.

The undersigned Patient or Legal Guardian authorizes and requests that payment of any third-party or insurance company benefits be made to Carteret Children's Clinic for any services or items supplied to the Patient. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

Consent for Protected Health Information Communication

The undersigned Patient or Legal Guardian hereby authorizes Carteret Children's Clinic to communicate with me by my preferred method as well as phone, voice mail, text, postal mail, email and fax regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance and billing issues, and any issues pertaining to the Patient's clinical care, including laboratory results among others. For email, fax, and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email, fax and/or text communication as selected. **If I authorize only my preferred method of communication, I will notify the practice and complete the Communication Restriction form.** I have the right to request that Carteret Children's Clinic restrict how it uses or discloses the Patient's PHI to carry out TPO, however, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Consent for Use and Disclosure of Protected Health Information

The undersigned Patient or Legal Guardian hereby authorizes Carteret Children's Clinic to use and disclose the Patient's protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO). I have been given a copy of and had the opportunity to review Carteret Children's Clinic Notice of Privacy Practices and Patient Rights and Responsibilities prior to signing this consent. I have been notified that release or disclosure of PHI may only occur with a valid consent unless it is an emergency or for other exceptions as detailed in the **General Statutes or in 45CFR 164.512 of HIPAA**.

Patient Rights

The undersigned Patient or Legal Guardian has been informed of their right to treatment, including access to medical care and habilitation, regardless of age, or degree of MH/DD/SA disability. I have been informed and given opportunity to review the Disability Rights NC and Patient Rights which are visibly posted in the patient waiting room.

Treatment plans for counseling services will be reviewed and provided in writing at the follow-up appointment by the counselor within 15 business days. Clinical summaries from a medical visit can be obtained via the patient portal within 3 business days.

(continued on other side)

SIGNATURE REQUIRED ON REVERSE

Revocation of Consent

The undersigned Patient or Legal Guardian has been informed of their right to revoke consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. I may inspect the PHI to be disclosed as described in the document. Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I have the right to refuse to sign this authorization and that treatment of the patient will not be conditioned on signing.

I have read and understand the above certifications, authorizations, consents and rights. I have had a chance to ask any questions about these items and all my questions were answered to my satisfaction.

Signature of Parent or Legal Guardian: _____ **Date:** _____

Please print name in full: _____ **Relationship to patient:** _____



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**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 _____;
- | | |
|---|---|
| <input type="checkbox"/> immunization records | <input type="checkbox"/> educational testing results (CCC only) |
| <input type="checkbox"/> history and physicals | <input type="checkbox"/> developmental/psychological information (CCC only) |
| <input type="checkbox"/> lab results, x-rays, diagnostic test results | <input type="checkbox"/> medication sheet, medication information |
| <input type="checkbox"/> other _____ | <input type="checkbox"/> 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: _____ Carteret Clinic for Adolescents and Children _____
 Address: _____ and Children _____
 City, State Zip: _____ 3510 John Platt Drive _____
 Phone Number: _____ Morehead City, NC 28557 _____
 _____ 252-726-0511 _____
 _____ FAX: 252-726-7441 _____

Purpose of Disclosure

- | | |
|---|--|
| <input type="checkbox"/> continuing medical care | <input type="checkbox"/> personal use |
| <input type="checkbox"/> referral | <input type="checkbox"/> insurance request |
| <input type="checkbox"/> legal proceedings (name of attorney) | |
| <input type="checkbox"/> other _____ | |

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. **There may be a charge to produce medical records.**

Parent/legal guardian signature: _____ Date: _____

Please Print: _____ Relationship to Patient: _____

Witness: _____ Date: _____