556 Sandhurst Drive
Fayetteville, NC 28304

(910) 483-2646
Fax (910) 483-9470

www.legacypeds.com

Records Release

Date of Request: _____

Name of Doctor or Clinic to Release Records, Phone and Fax numbers:

_____

_____

Name of Parent or Legal Guardian: _____

Patient Name and Date of Birth: _____

Request Records to be Forwarded to:
Legacy Pediatrics
556 Sandhurst Drive
Fayetteville, NC 28304

Mail _____ **Fax** _____ **Hand Carried** _____

Records to Transfer:

_____ All Records

_____ Clinic Visit-Notes

_____ Shot Records

_____ All Growth Charts

_____ Records for a Specific Date: _____

_____ Master problem List/Flow Sheet

_____ Medical Summary

_____ Last Physical Exam

_____ Asthma Action Plan and/or ADD visit

- I understand that I may revoke this authorization at any time by notifying the office in writing. I understand this authorization expires 180 days from the date signed.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws/regulations.
- I understand that photocopy or facsimile of this authorization is as valid as the original.

_____

Parent/Legal Guardian Signature Date

_____

Witness Date