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Karen J. Walter, MD, FAAP

MOUNTAIN AREA PEDIATRICS

500 Centrepark Drive, Asheville NC 28805 • 828.254.4337 • www.mountainareapeds.com

MEDICAL RECORDS REQUEST

Patient Legal Name: _____ DOB: _____ Phone Number: _____

I authorize the use or disclosure of the above named individual's health information as described below.

Information to be disclosed by:
Mountain Area Pediatrics
500 Centrepark Drive
Asheville, NC 28805
Ph: 828-254-4337 Fax: 828-252-2245
medicalrecords@mountainareapeds.com

And is to be provided to:
Person, Physician/Practice: _____
Address: _____
Phone: _____ Fax: _____
Email: _____

Purpose for request: ☐ Transfer of Care ☐ Personal ☐ Other: _____

Information to be disclosed:

- ☐ **Standard (last 3 years of notes, labs, consults & immunization record)**
- ☐ **Specific Dates: _____ to _____**
- ☐ **Immunization Record**
- ☐ **Form: ☐ School Excuse ☐ Daycare or Sports Form ☐ Requested Letter ☐ Other _____**
- ☐ **Entire Medical Chart**

* One complimentary copy of the patient chart will be sent upon request. All additional copies will include a charge. Payment must be received before additional requests are fulfilled.

* I understand that this authorization will expire 365 days from the date it is signed unless I have specified a different expiration date specified here _____

* I understand that I may cancel this authorization at any time by notifying in writing the MAPA Privacy Officer, 500 Centrepark Dr, Asheville, NC 28805, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

* I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

*I understand that MAPA will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

* I understand I am entitled to a copy of this signed authorization.

By Signing below, I acknowledge that I have read and understand this authorization:

Parent or Legal Guardian Name: _____ Relationship to patient: _____

Parent or Legal Signature: _____ Date: _____