



Blue Sky Pediatrics
Asheville

5 Walden Ridge Drive
Asheville, NC 28803
(828) 687-8709 phone, (828) 687-0252 fax

REQUEST FOR RELEASE OF MEDICAL RECORDS

Regarding Patient:

Last Name		First Name	Middle	
Street Address		City	State	ZIP
Date of Birth		Social Security Number		

Information Released From:

Name (Health Care Provider)

Street Address

City State ZIP

Phone Fax

Information Released To:

Blue Sky Pediatrics Asheville
Name (Health Care Provider)
5 Walden Ridge Drive
Street Address
Asheville NC 28803
City State ZIP
828-687-8709 828-687-0252
Phone Fax

Purpose for Release of Records: Please check one of the following:

Transferring to other Physician/Practice Continuing Treatment
 Other: (Please Specify) _____

Please check all of the following that you give permission to release:

Medical Records Mental Health Records School Evaluations

I hereby release you from all legal responsibility or liability that may arise from this authorization.

_____ Signed (Full Name)	_____ Printed Name	_____ Relationship to Patient
_____ Home Phone Number	_____ Work Phone Number	_____ Date
_____ Witness		

By signing above, I do hereby consent and authorize you to release copies of medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of the medical records. This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information related to pregnancy, sexually transmitted diseases, HIV Testing, AIDS, and any AIDS-Related syndromes. It also includes any information concerning Cancer, Cancer Testing, and Cancer Results. I agree that a copy of this release or fax of this release shall be as valid as the original release. Unless otherwise revoked, this Authorization expires one year from the date it is signed. This Authorization may be revoked at any time. The revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request. To revoke the authorization, the parent/legal guardian must submit a revocation request in writing to Blue Sky Pediatrics. Blue Sky Pediatrics will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this authorization.