Dr. Maria Castro

500 Holly Springs Rd Ste. 101 Holly Springs NC 27540

P-919-762-5113 **F-919-762-5130**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FORM

I _____ hereby authorize STARLIGHT PEDIATRICS to obtain health records as a transfer for the following patients:

_____	_____	_____
Last Name	**First Name**	**Birthday**
_____	_____	_____
Last Name	**First Name**	**Birthday**

From the following provider and city: _____

Contact number of doctor: (_____) _____ - _____ Phone / Fax

Please include the following:

__Complete health record **__ X-rays/labs** **__Immunization records**

__ Last physical exam **__ Other: __**_____

Signed: _____ Relationship: _____ Date: _____

Printed: _____ Phone: _____

1. I understand that this authorization will expire on (insert date) _____.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Starlight Pediatrics in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my child/ren's ability to obtain treatment, or to process payments.
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

This authorization is effective the moment it is signed. All the information would be solely used for medical purpose. Starlight Pediatrics follows all the norms and laws stablished by HIPPA for medical practices.

Please send the records to Starlight Pediatrics at 919-762-5130. If you have any questions please contact our office at 919-762-5113 Thank you