TRANSFER OF RECORDS TO UNIFOUR PEDIATRICS PA

PATIENT AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION

(Use ONLY if you are transferring care to Unifour Pediatrics, PA - David M. Millsaps MD, FAAP)

I, _____ understand that:
Parent's Name (or patient's if over 18)*

_____

_____

_____

is authorized by me to use or disclose my child's* protected health information for the purpose of transferring my child's* healthcare to Unifour Pediatrics PA (David M. Millsaps MD, FAAP). I have read this authorization and understand what information will be used or disclosed, who may use or disclose this information, and the recipient(s) of that information. I specifically authorize any current employee or owner of _____ to disclose my child's* protected health information as described on this form **to Unifour Pediatrics PA**. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. *(* = if patient over 18 yrs, substitute "my" for "my child's)*

☐ The patient's entire medical record or ☐ Other:

Send records (by postal mail … or hand-deliver) to:

Records Department
Unifour Pediatrics PA
P.O. Box 1347,
Hickory, NC 28603-1347

I fully understand and accept the terms of this authorization.

_____ _____
Parent's Full Signature (or Patient's if over 18)* Date

_____ _____
Patient's Full Name Date of Birth

SEND THIS FORM TO THIS ADDRESS:
Records Department
Unifour Pediatrics PA
P.O. Box 1347,
Hickory, NC 28603-1347

OR HAND-DELIVER TO:
Unifour Pediatrics PA
3411 Graystone Place, Conover NC 28613
directly across the street from:
Catawba Valley Medical Center
Phone 828-328-1118, FAX 828-328-1119

CALL 328-1118 IF YOU NEED ADDITIONAL RECORDS TRANSFER FORMS