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

(Please allow a minimum of 7-10 business days to process)
(1-15 pages $10.00) (16-100 pages, $.50 each page) (page 101+, .25 each page)

____
Patient's Last Name First Name Date of Birth

____
Street Address City State ZIP

Information Released From:

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

Information Released To:

____
Name (Health Care Provider
____
Street Address
____
City State ZIP
____
Phone Fax

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

_____to send to another medical practice (not transferring out of Blue Sky Peds)
_____to a school nurse
_____for my own personal records (charges apply)
_____for legal purposes (specify reason) (charges apply), Reason:____
_____other (specify reason) (charges apply), Reason:____
_____to transfer to another medical practice/primary care physician (specify reason)
    _____easier access/location _____insurance issue _____over age 18 _____dissatisfaction
    _____other (specify reason), Reason:____
_____moving (list new address)
    street address:_______________________________________Town/State/Zip_____________________________
    new phone number:___________________________________

Please check all of the following that you give permission to release: (charges apply unless being sent to another medical office)

_____All Medical Records (charges apply)
_____Mental Health Records (charges apply) ______Alcohol/drug related information (charges apply)
_____Immunization record only (no charge) _____Last Physical Exam only (no charge)
_____Standard Summary Sheet with Immunization record (no charge)

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

By signing above, I do herby 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.