BAILLIARD HENRY PEDIATRIC CARDIOLOGY

G. William Henry, MD
Frédérique Bailliard, MD MS

MEDICAL RELEASE OF INFORMATION FORM

Patient Name:_________________________________ Date of Birth:_________________________

Social Security #:______________________________

I request and authorize ☐ Hospital/ER _____________________ ☐ Other specialist _______________
☐ Primary care physician ________________

to release the medical records of the above named patient to:

Bailliard Henry Pediatric Cardiology PLLC
4301 Lake Boone Trail, Suite 300
Raleigh NC 27607
Fax 919 896 7494; Tel 919 890 5566

This request and authorization applies to: *(initial either line 1 or 2)*

1. __**All** personal health information (PHI) relating to treatment from ___/___/___ to ___/___/___ :
This information may contain x-ray reports, laboratory reports, EKG reports, other diagnostic reports, consults, etc.

2. ____ The following PHI relating to treatment from ___/___/___ to ___/___/___ :

☐ History and Physical Examination
☐ Labs, X-Ray, any diagnostic report
☐ Medication lists
☐ Clinic notes
☐ Discharge Summary
☐ Consult Notes
☐ Operative reports

This request and authorization also applies to:

____All Health Care information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (*Please initial and circle all that apply*)

I understand I have the right to revoke this authorization by providing a written request to do so to ***Bailliard Henry Pediatric Cardiology, PLLC***. I understand that the revocation will not apply to information that has already been released and will take effect on the date that the request is received.

Unless otherwise revoked, this Authorization will expire twelve months from the date signed. I understand that authorizing the disclosure of this health information is voluntary.

I understand that ***Bailliard Henry Pediatric Cardiology, PLLC*** assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release ***Bailliard Henry Pediatric Cardiology, PLLC*** from all legal liability that may arise from this authorization.

By signing this form, I authorize ***Bailliard Henry Pediatric Cardiology, PLLC*** to request and use the PHI described above.

______________________________________ ________________________________
Signature of Parent/Guardian/Adult Patient Date

____
Relationship to Patient

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