Storr Records Management

Custodian of the medical records for:

Sunrise Pediatric Associates, PA

Storr Records Management
9221 Globe Center Drive, Suite 100
Morrisville, NC 27560
Phone: 919-313-3700
Website: www.storrrecords.com

Sunrise Pediatric Associates, PA
1520 Sunday Drive, Suite 217
Raleigh, NC 27607

Date: _____

To Storr Records Management:

I am writing to request a copy of _____'s medical records. I am: The parent _____
The legal guardian (requires power of attorney or court order)_____
The court appointed guardian (requires power of attorney or court order)
_____

_____(patient's name) was formerly a patient at Sunrise Pediatrics. Attached is the signed authorization to release their medical records. I am requesting the records because of a change in providers.

Thank you for your attention to this matter.

Sincerely,

_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

1. PATIENT INFORMATION.

Patient Name: _____

Patient Address: _____

_____, ___ _____

Date of Birth: _____

2. AUTHORIZATION FOR RELEASE. I hereby authorize Storr Records Management for Sunrise Pediatrics to release, disclose, and deliver the medical information file to:

Authorized Recipient:

_____

_____

_____, ___ _____

Email Address:_____
(Email Address Preferred)

Fax Number:_____

3. SPECIFIC AUTHORIZATION. I specifically authorize the release of all medical information relating to the above-named patient including but not limited to the following categories protected by state or federal law: (1) Substance abuse (drug or alcohol) treatment (2) Mental health treatment and (3) HIV-AIDS-related information, if such information is contained in the records. This request includes any reports, correspondence, test results, and any other information contained in the records, whether generated by the authorized provider or another entity.

I do not give permission for any other use or redisclosure of this information.

Dated: _____

_____
Parent/Guardian

4. REDISCLOSURE. This release does not authorize redisclosure of medical information beyond the limits of this consent. The Recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization. The following written statement should accompany certain disclosures:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and 45 CFR Parts 160 and 164). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and 45 CFR Parts 160 and 164. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I specifically understand and agree that the REDISCLOSURE requirements set out above will apply to these records.

5. VALIDITY. I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorize the release of the information as indicated above.

Dated: _____

_____

Parent/Guardian