

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:

David M. Millsaps MD, FAAP
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:

David M. Millsaps MD, FAAP
Unifour Pediatrics PA
P.O. Box 1347,
Hickory, NC 28603-1347

OR HAND-DELIVER TO:

David M. Millsaps MD, FAAP
Unifour Pediatrics PA
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