Stepping Stones Pediatrics

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Consent Form for Release of Information

(request for incoming records)

Child's Name ______________________________

Date of Birth ______________________________

Social Security # ____________________________

Facility/Physician's office being asked for information:

Facility/Physician Name ____

Address ____

City/State/Zip ____

Phone ______________________________ **Fax** ______________________________

I, ______________________________ **authorize the above facility to release specified information concerning the child listed above to:**

Stepping Stones Pediatrics
10941 Raven Ridge Road
Suite 105
Raleigh, NC 27614

This data shall include: ***(check all that apply)***

□ **vaccination records**	□ **growth charts**	□ **outpatient records**
□ **lab data**	□ **inpatient records**	□ **complete records**
□ **consultations**	□ **x-ray reports**	□ **other** __________________

The purpose of releasing this data shall be:

□ **medical follow-up** □ **insurance** □ **personal** □ **legal** □ **other** ________________

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will automatically expire after 90 days from the date on which it is signed. This authorization and request is fully understood and is made voluntary on my part.

Signature ____________________________________ **Date** ___ / ___ / ___

Relationship to Patient ________________________