Virginia Pediatrics and Adolescent Medicine, PLC
5275 Lee Highway Suite 200
Arlington, VA 22207
(703)717-4090 phone (703)717-4091 fax

GENERAL MEDICAL RECORD RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete the following information:

Patient Name: ____ Date of Birth: ________________________

Address: ____

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Telephone: ________________________

I authorize the custodian of records of:_____________________ or other person/entity (specifically describe) ____________________ to disclose/release the following information* Check all applicable:

____ All Records ___ Laboratory/Pathology Records ____ X-ray/Radiology Records

___ Abstract/Summary ___ Pharmacy/Prescription Records ___ Billing Records

___ Other(describe specifically) ____

*Note if these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted disease you are hereby authorizing disclosure of this information.

RELEASE: ____TO ___ FROM Virginia Pediatrics and Adolescent Medicine

5275 Lee Highway Suite 200

Arlington, VA 22207

___TO ___FROM ____________________________________

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I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

____________________________________ ____

Signature of patient or patient's legal representative Date

____________________________________ ____

Printed name of patient representative Representative's authority to sign for patient

Release of Record Fee: $0.25 per page for paper charts and $0.25 per encounter for electronic record printing. Records if mailed will be sent priority mail and the fee is $6.00 for postage. This is patient's (or his/her legal representative) responsibility to cover these costs.

FEE PAID ________

A copy of this signed authorization must be given to the individual.