Virginia Pediatric and Adolescent Medicine, PLC
5275 Lee Highway, Ste. 200
(T) 703-533-1580 (F) 703- 533-1689

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient _____	
Address _____	
Phone Number _____	**E-mail** _____
Birthdate _____	**Social Security Number** _____
Other Aliases _____	

Name of Guardian or Legal Representative _____	
Address _____	
Phone Number _____	**E-mail** _____

I hereby authorize the following health care professional Virginia Pediatric and Adolescent Medicine, PLC to release (Check one)

☐ all health information about me ☐ my medical records as described on the following page:

Person/Organization to Release Information _____		
Street Address _____		
City _____	**State** _____	**Zip Code** _____
Phone Number _____	**Fax Number** _____	

The following health information that relates to service beginning from _____ [Date] to _____ [Date], may be released: (Check one)

☐ Entire medical record (including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers)

☐ Only the following: (Check all that apply)

- ☐ Patient histories
- ☐ Office notes (except psychotherapy notes)
- ☐ Test results
- ☐ Radiology studies
- ☐ Films
- ☐ Other: _____
- ☐ Referrals
- ☐ Consults
- ☐ Billing records
- ☐ Insurance records
- ☐ Records sent by other health care provide

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Reason for request:

- ☐ Change of doctor
- ☐ Individual request
- ☐ Workers compensation
- ☐ Specialist referral
- ☐ Insurance purposes
- ☐ Continued treatment
- ☐ Legal investigation
- ☐ Other: _____

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Patient's Signature	**Patient's** Name	Date
Guardian or Legal Representative's Signature	**Guardian or Legal Representative's** Name	Date

Release of records fee: $0.25 per encounter, if records are mailed they will be sent priority mail and the fee is **$7.00** for postage.

FEE PAID: $