Virginia Pediatrics and Adolescent Medicine, PLC

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Arlington, VA 22207

(703)533-1580

vapeds@gmail.com

Date:_____

I _____the undersigned, parent of _____

(Parent or Legal Guardian Name) (Minor Child)

DOB: ____/_____/_____ request that the following specific information be emailed to the

Following email address: _____@_____

Requested Information Check all applicable:

Immunization Record ___ School related forms_____

Laboratory/Pathology Records __ X-ray/Radiology Reports ____

Pharmacy/Prescription Records ____ Billing Records _____

_ Other (describe specifically) _____

Please note: email is not considered a secure means of transmission for health protected information. We will be happy to email with your signature, or we can mail to your home address. You may also pick the requested documents up at the office.

I understand the risks of using email and request that my information above be sent via email. This authorization is only valid for this single request and must be renewed each time you request we communicate with you via email.

Parent or Legal Guardian Live Signature. Electronic Signature not valid.