Virginia Pediatrics and Adolescent Medicine, PLC
5275 Langston Blvd Suite 200
Arlington, VA 22207
(703)533-1580 phone (703)533-1689 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: _____

_____

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 Langston Blvd Suite 200

Arlington, VA 22207

___TO ___FROM _____

_____

_____

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: $0.35 per page up to 50 pages, $0.18 for each additional page for record printing. An administrative fee will be added to any and all request of $20.00. If records are mailed the fee for postage is based upon weight and priority. This is patient's (or his/her legal representative) responsibility to cover these costs. Records may take up to 15 business days for release.

FEE PAID _____

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