46440 Benedict Drive, Suite 207
Sterling, VA 20164-6602
Phone (703) 444-2100
Fax (703) 444-0386

224-D Cornwall Street NW Suite 104
Leesburg, VA 20176
Phone (703) 779-0699
Fax (703) 779-7712

Completed Request Forms May Be Returned by Fax.

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: ____________________________________ D.O.B.__________________

PATIENT NAME: ____________________________________ D.O.B.__________________

PATIENT NAME: ____________________________________ D.O.B.__________________

PATIENT NAME: ____________________________________ D.O.B.__________________

I declare that I am the parent/legal guardian of the above named patient(s), and hereby request and authorize Pediatric Healthcare, P.C. to release copies of their medical records, including diagnosis, treatments, prognosis, recommendations, and other data to include insurance information. Lab, radiology, specialist reports or any other information from other providers regarding the patient and in our possession may be copied and released.

I am aware that records may contain HIV/AIDS results, sexually transmitted disease, reproductive health, alcohol/drug abuse, child or adult abuse and mental health information and consent to their release.
Initial: ________ Date: _____________

SELECT FROM THE FOLLOWING:
1. ___________I request **ALL** of the medical records for each patient.
2. ___________I request records from the following dates: ________________ to ___________________.
3. ___________Other, please specify: ____.

Fees for Records Copying
The cost of supplies and a copy preparation fee as allowable by Virginia's Health Records Privacy statute 32.1-127.1:03 J will apply. This fee is determined by a per page fee plus labor and if applicable postage. You will be notified by phone when copying is complete and of the total cost.

Please allow fifteen (15) business days to process your request. You will be notified by phone when copying is complete and the records are ready for pick up. **You may be required to present proof of identity when picking up records**. Records will only be mailed if you are moving out of the area, and then will only be mailed DIRECTLY TO YOU for confidentiality and security reasons.

Parent/Guardian Name____

Address____

Daytime Phone Number____

Purpose of Disclosure:
Moving Out of Area _______ Changing Doctors _______ Switch to Adult Physician ___________
Insurance Change _______ Referral to Specialist _____ Legal Purposes ____________________
Disability Determination____ Other (please specify) ______________________________________

Your signature authorizes the release of your/your child's medical records and constitutes your consent to pay Pediatric Healthcare, P.C. for fees as billed.

Signature **(required)** Date **(required)**

10/07