Reston Pediatrics

PRESCRIPTION RELEASE FORM

Name of Patient:_____ **Date of Birth:**_____

Street Address:_____ **City, State, Zip Code:** _____

Home Phone Number: _____ **Cell Phone Number:**_____

I, _____, do hereby authorize Reston Pediatric Associates to release the following prescriptions:

☐ **ALL PRESCRIPTIONS**
☐ **CONTROLLED SUBSTANCES**

To the individual(s) specified below:

Name of the Company/Agency/Facility/Person: _____

Street Address: _____

City, State, Zip: _____

☐ I AUTHORIZE_____ TO **PICK UP** MY PRESCRIPTIONS*
☐ PLEASE **MAIL** MY PRESCRIPTIONS TO THE ADDRESS PROVIDED ABOVE

Please provide a current phone in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 6 months from the date of signature. I understand that I may cancel this request with written notification but that will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would no longer be protected by federal regulation.

Identification Required

_____Date _____
Signature of Patient (must be over 18), Parent. Or Legal Guardian