Reston Pediatrics

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

NOTE: Please allow 30 DAYS for the records to be processed and released

Patient's Full Name: _____ Patient's 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 medical records of the above named individual to the individual(s) specified below.

PLEASE MARK BOX AS NEEDED

☐ ALL RECORDS ☐ IMMUNIZATION RECORDS ONLY ☐ OTHER

If other, please specify_____

☐ I DO
☐ I DO NOT

Authorize release of information related to AIDS or HIV infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug use.

RELEASE INFORMATION TO:

☐ I WILL PICK UP MY RECORDS
☐ PLEASE FAX MY RECORDS
☐ PLEASE MAIL MY RECORDS
☐ PLEASE MAIL A CD OF MY RECORDS

_____
NAME OF THE COMPANY / AGENCY / FACILITY / PERSON

_____
STREET ADDRESS

_____
CITY, STATE, ZIP FAX NUMBER

PURPOSE OF DISCLOSURE:

☐ **REFERRAL TO A SPECIALIST** ☐ **INSURANCE CHANGE** ☐ **SWITCH TO ADULT PHYSICIAN**
☐ **CHANGE DOCTORS** ☐ **LEGAL INVESTIGATION** ☐ **DISABILITY DETERMINATION**
☐ **MOVING OUT OF AREA** ☐ **SCHOOL REQUIREMENT** ☐ **OTHER**

If other, please specify_____

_____

IS THIS A PERMANENT TRANSFER? ☐ YES – EFFECTIVE _____/_____/_____ ☐ NO

PLEASE PROVIDE A CURRENT PHONE NUMBER 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 12 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 ve subject to disclosure by the person or class of persons or facility receiving it, and would no longer be protected by federal regulation. I understand that the medical provider to whom this is authorized may not condition their treatment of me whether or not I sign the authorization.

_____ _____
Signature of Patient (must be over 18), Parent, or Legal Guardian Date

*THERE IS A FEE FOR MEDICAL RECORDS TO BE PRINTED (CODE OF VA 8.01-413 APPLIES)
PAGES 1-50 = $0.50 PER PAGE
PAGES 51 & ABOVE =$0.25 PER PAGE
**THERE IS A FLAT $12 FEE TO MAIL MEDICAL RECORDS ON CD
***THERE IS A FLAT $6 FEE TO MAIL MEDICAL RECORDS
****A MAXIMUM OF 5 PAGES CAN BE FAXED

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