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 (5pg. max)
☐ PLEASE MAIL MY RECORDS**
☐ PLEASE MAIL MY RECORDS ON CD***
☐ PLEASE EMAIL MY RECORDS

_____
NAME OF THE COMPANY / AGENCY / FACILITY / PERSON

_____
STREET ADDRESS

_____
CITY, STATE, ZIP FAX NUMBER

_____
EMAIL ADDRESS

☐ **For email communication,** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication as selected.

PURPOSE OF DISCLOSURE:

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

If other, please specify_____

_____

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

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete. I understand I have the right to revoke this authorization at any time. I acknowledge I may inspect or copy the protected health information to be disclosed as described in this document. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____
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
**ABOVE PRINTING CHARGES APPLY TO MAILED RECORDS AS WELL AS SHIPPING FEE
***THERE IS A FLAT $16.50 FEE TO EMAIL MEDICAL RECORDS OR TO MAIL THEM ON CD