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Pediatric and Adolescent Health Partners, P.C.

Authorization for Medical Information Release

(Print Patients Full Legal Name)

(Patients Date of Birth (mo/day/year))

(Street Address Where Patient Lives)

(Home Phone Number With Area Code)

(City, State, Zip Code)

(Alternate Phone Number With Area Code)

I, _____ do hereby authorize the release of: **All Reports**
Patient, Parent or Legal Guardian

_____ Discharge Summary

_____ Pathology Reports

_____ Emergency Reports

_____ History & Physical

_____ Laboratory Reports

_____ Other Hospital Reports

_____ Progress Notes

_____ Radiology Reports

_____ Other: _____

_____ Operative Notes

_____ ECG/EEG/Cardiac Cath

___ I Do ___ I Do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Information Released to:

___ **Pediatric and Adolescent Health Partners, P.C.** ___ other office _____

Information Released from:

___ **Pediatric and Adolescent Health Partners, P.C.** ___ other office _____

Medical records being obtained from Pediatric and Adolescent Health Partners, P.C. will be copied by Smart Corporation. There will be a charge of \$0.50 per page for the first 50 pages and \$0.25 per page for each additional page, plus the standard postage rate. Please enter your billing address for Smart Corporation.

(Print Responsible Party-Full Legal Name)

(Print Patients Full Legal Name)

(Billing Address)

(Relationship to Patient)

(City, State, Zip Code)

I hereby authorize disclosure of the health information for the above 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 it 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, class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorization is furnished, may not condition the treatment of the patient on whether or not this authorization is signed.

Signature of Patient (over 18 yrs old), Parent or Legal Guardian

Date of Signature

Midlothian Village
13821 Village Mill Drive, Suite A
Midlothian, VA 23114
(804) 794-2821

Better Living Center
13825 Village Mill Drive
Midlothian, VA 23114
(804) 794-2821

Bon Air Building
8719 Forest Hill Avenue
Richmond, VA 23235
(804) 320-7161