



PEDIATRIC AND ADOLESCENT HEALTH PARTNERS

www.pahpartners.com

Ted R. Abernathy, M.D., FAAP
 Peter P. Blakey, M.D., FAAP
 Julia H. Mills, M.D., FAAP
 Joel C. Everett, M.D., FAAP
 Patricia D. Mulreany, M.D., FAAP
 Edward M. Henderson, DO

Christine W. Seliskar, M.D., FAAP
 Wendy L. Garrity, M.D., FAAP
 Jonathan K. Mason, M.D.
 Sarah D. Trezza, PA-C
 Katherine E. Bailey, CPNP

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 from another office: _____

To Pediatric and Adolescent Health Partners, P.C:

- Midlothian Village, 13821 Village Mill Drive, Su. A, Midlothian, Va. 23114 **Office:(804)794-2821; Fax:(804)794-4072**
- Bon Air Building, 8719 Forest Hill Avenue, Richmond, Va. 23235 **Office:(804)794-2821; Fax:(804)320-4634**
- Powhatan Building, 3864 Old Buckingham Rd. Su. B, Powhatan, Va. 23139 **Office:(804)794-2821; Fax:(804)372-9317**

Reason for leaving Pediatric and Adolescent Health Partners,P.C: _____

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 Office
 13821 Village Mill Drive, Suite A
 Midlothian, Va. 23114

Bon Air Office
 8719 Forest Hill Ave.
 Richmond, Va. 23235

Powhatan Office
 3864 Old Buckingham Rd., Suite B
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